



ALABAMA  
HEALTH  
DISPARITIES  
STATUS REPORT  
2010

ADPH



OMH

Office of Minority Health



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## **A MESSAGE FROM THE STATE HEALTH OFFICER**

I am pleased to present the *Alabama Health Disparities Status Report 2010*. In Alabama, racial and ethnic minorities have higher rates of disease, injury, premature death, and disability. Disparities exist in both access to care and care received by minorities. These disparities can mean shorter life expectancy, decreased quality of life, loss of economic opportunities, and social inequality.



Underlying issues such as lifestyle behaviors, delayed care, trust between patient and provider, plus other factors such as education and physician shortages all contribute to health inequality among Alabama's minority populations or ethnic groups.

In the coming years in Alabama, we can work together to reduce the rates of disease by providing opportunities for intervention and improving access to care. We can also challenge individuals to adopt lifestyles that encourage physical activity, promote weight loss for those who are obese/overweight, and reduce smoking.

Please visit the Alabama Department of Public Health Office of Minority Health website at [www.adph.org/minorityhealth](http://www.adph.org/minorityhealth) for more information.

Donald E. Williamson, M.D.  
State Health Officer



Over the last decade, the U.S. population grew by 13 percent and increased in diversity at an even greater rate. Racial and ethnic minorities are among the fastest growing communities in the country and today comprise 34 percent of the U.S. population. By the year 2030, racial and ethnic minorities are projected to represent 40 percent of the U.S. population.<sup>1</sup> In the midst of this increasing diversity, improvements in the overall health status of Americans are linked to improvements in the health status and health outcomes of minority populations.

Despite the great advancements in health care, racial and ethnic minority populations continue to experience poorer health outcomes resulting in higher levels of illness and death. Minorities comprise 52 percent of the uninsured and suffer from illness and death at a greater rate than Whites.<sup>1</sup> Eliminating health disparities will require new knowledge about the factors that contribute to these disparities, such as poverty, unequal access to care, and education. It also will require enhanced methods for disease prevention and health promotion, as well as new approaches to engage and assemble affected communities, by creating new health partnerships focused on eliminating health disparities.

It is anticipated that minority populations will increase to almost 50 percent of the total U.S. population by 2050.<sup>15</sup> Therefore, eliminating health disparities is a priority for the Alabama Department of Public Health (ADPH) Office of Minority Health (OMH) and the ADPH Health Disparities Advisory Council (HDAC). This Status Report has been developed to assess the health status of all Alabamians, and is to be used as a tool to develop initiatives to reduce or eliminate health disparities that exist, especially in minority populations.



**Purpose**—The purpose of this report is to compile data and pertinent information from a variety of sources within Alabama’s Public Health and Mental Health Departments. The information provides a description of the health, lifestyle, and social and economic conditions which often can be attributed to health disparities which affect multi-cultural populations in Alabama.

**Background**—Alabama has been ranked as one of the worst states in terms of health as compared to the nation for a number of years. Not only is the overall health poor in Alabama when compared to other states, but the health disparities between African Americans and Whites are considerable. The Office of Minority Health is actively working with chronic disease program managers, through initiatives outlined by the ADPH Health Disparities Advisory Council, to reduce or eliminate health disparities among minority populations.

**Limitations of Public Health Data**—This report draws together data and information from a variety of sources. There are some limitations to the available data, but the Department has used the most current data available for each disparity discussed in this report.

**Race/Ethnicity and Reporting**—The terms “African Americans,” “American Indians/Alaska Natives (AI/AN),” “Asian Americans,” “Hispanics/Latinos,” “Native Hawaiians/Pacific Islanders (NH/PI),” and “Whites” will be used throughout this report to refer to racial and ethnic categories in Alabama. The terms have been chosen because they are generally preferred categories. Alabama’s racial data are limited mostly to African Americans and Whites. African Americans comprise nearly 82.75 percent of the minority population in Alabama, and the numbers for Asian Americans, Pacific Islanders, and American Indians are limited. Additionally, the numerators for Hispanics/Latinos and multicultural (Other) populations make statistical rates unreliable. Therefore, much of this report’s focus is typically on African Americans.<sup>2</sup>

**Poverty**—Poverty data is based mostly on U.S. Census data. Because the census is completed every ten years, the report is limited to projections based on best estimates for the interim years.

**Education**—There is a strong relationship between educational attainment and health status. According to the 2000 Census of Population, nearly one-third (30.3 percent) of all rural Alabama residents age 25 years or older had less than a high school education. This exceeds the 20.2 percent of urban residents in this age group with less than a high school education.<sup>2</sup> Providing rural students with the educational opportunities to compete with urban counterparts may help in reversing the health status of rural Alabama residents.

**Gaps—Insurance, Under-Insured, and Uninsured**—Medicaid is the leading agency of the U.S. health care system that provides coverage for almost 60 million Americans not covered by private health insurance and finances 16 percent of national health spending. Medicaid coverage of the low-income population provides access to a comprehensive scope of benefits with limited cost-sharing that is geared to meet the health needs and limited financial resources of Medicaid’s beneficiaries who tend to be sicker and poorer than the privately insured low-income population.<sup>3</sup> In 2009, 46.3 million persons (15.4 percent), all ages, were



uninsured; 58.5 million (19.4 percent) had been uninsured for at least part of the year; and 32.8 million (10.9 percent) had been uninsured for more than a year. The average household income in 2009 was \$40,888.<sup>4</sup>

**Access to Health Care Poses a Challenge in Rural Alabama**—There are 60 primary care health professional shortage areas in Alabama. The potential number of patients for each rural Alabama primary care physician in 2006 was approximately 2,160 compared to only 1,250 for those practicing in urban counties.<sup>5</sup>

Access to health care in rural counties in Alabama can be a challenge because:

- Eight rural Alabama counties do not have hospitals.
- Thirty five of 55 rural Alabama counties do not provide labor and delivery service.
- The average time from call to arrival at the scene of an emergency for rural county emergency medical services is over 27 percent greater than the response in urban counties.
- The motor vehicle accident mortality rate in 2005-2007 for rural Alabama residents was nearly 46 percent higher than that for urban county residents and was more than double the rate for the nation.
- Hospitals in rural Alabama counties had 25.1 general hospital beds per 10,000 residents in 2009 compared to 45.0 general hospital beds per 10,000 residents in urban counties.
- The potential number of patients for each rural Alabama dentist in 2007 was approximately 3,845 compared to 1,774 for those practicing in urban counties.<sup>5</sup>

**Limited English Proficiency (LEP)**—LEP individuals are those who are unable to communicate effectively in English because their primary language is not English and they have not developed fluency in speaking, reading, writing, or understanding the English language.

Some possible underlying reasons for these difficulties for LEP individuals are because they:

- Were not born in the United States.
- Speak a native language other than English.
- Come from environments where a language other than English is dominant.
- Are American Indian and Alaskan Natives and who come from environments where a language other than English has had a significant impact on their level of English language proficiency.



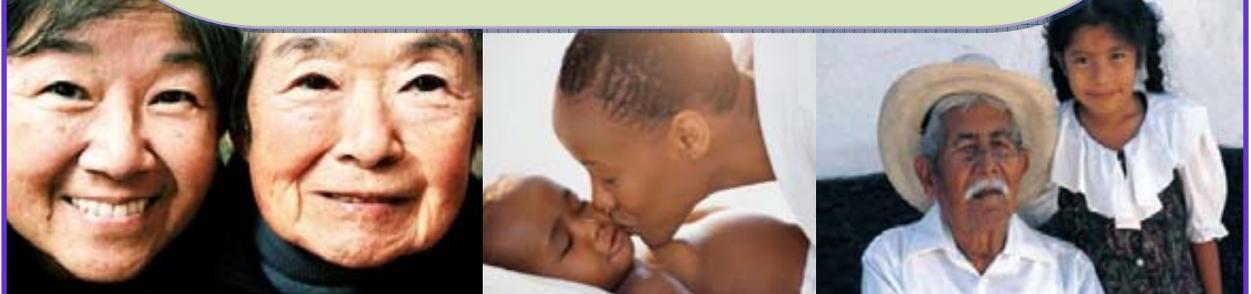
**Geographic Distribution**—This is a common measure because geographic distribution data is available from a variety of sources.

**Personal Health Data**—Information pertaining to conditions requiring hospitalization comes from hospital discharge records. Other information such as BMI (Body Mass Index) and health-related behaviors comes from self-reported surveys, such as Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavioral Surveillance System (YRBSS), and may be subject to inherent potential biases.<sup>7,8,9</sup>

**Methods**—This report presents final 2007-2009 data on U.S. deaths, death rates, life expectancy, infant and maternal mortality, and trends by selected characteristics such as age, sex, ethnicity, race, marital status, educational attainment, state of residence, and cause of death.



HEALTH DISPARITIES  
AND  
LIFESTYLE FACTORS





# **H** **HEALTH DISPARITIES—THE NATION**

## *Key Themes and Highlights from the 2009 National Healthcare Disparities Report (NHDR)*

Examining health care disparities is an integral part of improving health care quality. Health care disparities are the differences or gaps in care experienced by one population compared with another population. As the National Healthcare Disparities Report (NHDR) describes the quality of and access to care for multiple subgroups across the United States, the National Healthcare Quality Report (NHQR) also represents a source of information for tracking the nation's progress over time.

The NHDR report shows that some Americans receive worse care than other Americans. Within the scope of health care delivery, the disparities may be due to differences in access to care, provider biases, poor provider-patient communication, poor health literacy, or other factors.

The purpose of the NHDR, as mandated by Congress, is to identify the differences or gaps where some populations receive poor or worse care than others and to track how these gaps are changing over time. Although the emphasis is on disparities related to race and socioeconomic status, the reporting mandate indicates an expectation that the Agency for Healthcare Research and Quality (AHRQ) will examine health care disparities across broadly defined 'priority populations.' These include ethnic minorities and other groups or categories of individuals experiencing disparate and inadequate health care.

The NHDR and NHQR use the same measures, which are categorized across four components of quality for effectiveness, patient safety, timeliness, and patient centeredness. The 2009 NHQR report focuses on the state of health care disparities for a group of 'core' measures that represent the most important and scientifically credible measures of health care quality for the nation, as selected by the U.S. Department of Health and Human Services (HHS) Inter-agency Work Group. By focusing on core measures, the 2009 NHDR report provides a more readily understandable summary and explanation of the key results derived from the data.<sup>10</sup>

Three key themes emerge in the 2009 NHDR:

- Disparities are common, and being uninsured is an important contributor.
- Many disparities are not decreasing.
- Some disparities merit particular attention, especially cancer, heart failure, and pneumonia.

Efforts by AHRQ and HHS report on the biggest disparities in quality documented over the years where there has not been improvement in:

- Training providers.
- Raising awareness.
- Forming partnerships to identify and test solutions.

The 2009 NHDR shows that the uninsured face greater challenges than the insured in getting access to high quality health care. Moreover, based on analyses of a set of core quality measures, the factor most consistently related to better quality is whether a patient is insured.



# **H** **HEALTH DISPARITIES—ALABAMA**

Health disparities have been defined as differences in “the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates.” Health disparities exist across race/ethnic groups, geographic residence, gender, age, and disability status.<sup>11</sup> Determinants of health disparities are multi-factorial (a pattern of predisposition for a disease process) and include cultural factors, socioeconomic factors, racism/discrimination, and political factors.<sup>12</sup>

Race and ethnicity account for many of the disparities in the public’s health. Minority populations in the United States have higher rates of chronic disease, higher mortality, and poorer health outcomes than Whites. Alabama’s minorities often have poorer access to care than Whites. The minority populations include: African Americans, American Indians, Asian Americans, Hispanics/Latinos, and Native Hawaiians/Pacific Islanders. Although varying in magnitude by condition and population, disparities are observed in almost all aspects of health care.

Healthy People 2010 has highlighted how health disparities can occur among various demographic groups and has identified ten leading health indicators where health disparities exist. The leading health indicators for Alabama include: cardiovascular conditions and diseases, cancer, diabetes, HIV/AIDS, infant mortality, and mental health illness. Health disparities include, but are not limited to, the lack of physicians in rural areas, low health literacy, unequal treatment, and exposure to environmental risks.<sup>14</sup>

A risk factor increases a person's chance of developing a disease. A number of risk factors contribute to health disparities in Alabama. Risk factors that correlate to lifestyle behaviors for the ten leading health indicators include: tobacco usage and secondhand smoke, poor nutrition (lack of daily consumption of fruits and vegetables), obesity and overweight, and physical inactivity.

Access to care, health insurance coverage, use of preventive health services, and barriers to care all contribute to the cause of health disparities. As individual, community, social, and health system factors contribute to health care disparities, multiple strategies exist to address these factors. Efforts have focused on training health care professionals; raising awareness among health care professionals and patients; and changing health systems at the hospital, provider, and community level. The current disproportions in health care and increasing minorities in the U.S. substantiates the need to address and eliminate health disparities.

Shortage of health care professionals is a major problem in Alabama. Alabama has health professional shortage designation areas that are evaluated by the Primary Care and Rural Health Office of the Alabama Department of Public Health to ensure that the underserved communities may participate in federal and state programs targeting their unique needs. The shortage designations include Medically Underserved Areas (MUA), Health Professional Shortage Areas (HPSA), Mental Health Professional Shortage Areas (MHPSA), and Dental Health Professional Shortage Areas (DHPSA).<sup>5</sup>



# **N**UTRITION AND PHYSICAL ACTIVITY

The Nutrition and Physical Activity Division (NPA), located within the Bureau of Professional and Support Services of the Alabama Department of Public Health, serves as the focal point within the department to promote nutrition and physical activity as a part of a healthy lifestyle.

The division works across bureau lines while serving as the key link to external partners that have similar interests in healthy lifestyles. The division works to implement nutrition and physical activity interventions and to promote policy and environmental initiatives to increase the number of Alabamians who maintain a healthy weight, eat a balanced meal, and are physically active. Nutrition and physical activity are part of a healthy lifestyle that is addressed by NPA and other divisions, such as the Women, Infants and Children (WIC) nutrition program and the Strategic Alliance for Health (SAH).

Health professionals trying to influence dietary change and physical activity habits must take into account a person's personal food and activity preferences as well as their level of awareness and interest in making healthier choices. Environmental factors within families, organizations, and communities must also be considered.

The overall goals to promote a healthy lifestyle through nutrition and physical activity are:

- Consuming a healthy diet, with an emphasis on plant sources and increasing the consumption of fruits and vegetables.
- Decreasing serving sizes to better reflect caloric needs of the person.
- Increasing physical activity and decreasing physical inactivity.
- Achieving and maintaining a healthy weight throughout the life cycle.
- Drinking no more than one alcoholic beverage per day for women, or two per day for men, if one drinks alcohol.

Healthy lifestyles are promoted through community support and include:

- Coordinating public, private, and community organizations to create social and physical environments that support the adoption and maintenance of healthy nutrition and physical activity behaviors.
- Increasing access to healthy foods and nutritional information in schools, worksites, and communities.
- Providing safe, enjoyable, and accessible environments for physical activity in schools, worksites, and communities.

Eating right and being physically active are not just a “diet” or a “program”—they are important in obtaining a healthy lifestyle. With healthy habits, risks of many chronic diseases can be reduced while increasing chances for a longer life.



## UNDERWEIGHT CONCERNS

Reaching and maintaining an appropriate body weight is a healthy goal. Being either too thin or too heavy is not healthy. Many times being too thin is not discussed, but it has health risks as being obese does. Being too thin indicates the body is not getting enough calories to maintain proper cellular function. Not getting the correct nutrients can lower the immune system, leading to increased risk for illness and infections. Other problems with being too thin include an increased risk for anemia, hormonal deficiencies, and osteoporosis.

## OVERWEIGHT AND OBESITY CONCERNS

Being too thin, overweight, or obese are complex issues. The simple science is that weight maintenance is a balance of calories consumed versus calories expended. Being too thin is a real concern; however, in Alabama there are more cases of weighing too much. Even though overweight and obesity both cause concern when it comes to health issues, overweight and obesity terms should not be used interchangeably.

For adults, overweight and obesity ranges are determined by using weight and height to calculate a number called the "body mass index" (BMI). An adult who has a BMI between 25 and 29.9 is considered overweight. An adult who has a BMI of 30 or higher is considered obese. This translates to 30 or more pounds over an appropriate weight for height (refer to the BMI chart shown below).<sup>7</sup>

BMI provides a reliable indicator of body fatness for most people and is used to screen for weight categories that may lead to health problems.<sup>7</sup>

**BMI Table:**

Adult (21 and over)	
BMI Range	Weight Status
Below 18.5	Underweight
18.5-24.9	Normal
25-29.9	Overweight
30.0 and Above	Obese
Children and Adolescent (2-20 years)	
BMI Range	Weight Status
<5 <sup>th</sup> percentile BMI for age	Underweight
≥5 to <85 BMI for age/gender	Normal weight
≥85 <sup>th</sup> to <95 <sup>th</sup> BMI for age/gender	At risk for overweight
≤95th BMI for age/gender	Overweight
Not used in children/teens	Obese

**Example:**

Height	Weight Range	BMI	Considered
5' 9"	124 lbs or less	Below 18.5	Underweight
	125 lbs to 168 lbs	18.5-24.9	Healthy weight
	169 lbs to 202 lbs	25.0-29.9	Overweight
	203 lbs or more	30.0 or higher	Obese

BMI is a mathematical formula in which a person's body weight in kilograms is divided by the square of his or her height in meters, wt/(ht)<sup>2</sup> English Formula:

$$\text{BMI} = (\text{Weight in Pounds}) \text{ divided by } (\text{Height in Inches} \times \text{Height in Inches})$$



It is important to remember that although BMI correlates with the amount of body fat, BMI does not directly measure body fat. As a result, some people, such as athletes, may have a BMI that identifies them as overweight even though they do not have excess body fat.

However, it is with the BMI of 30 or higher that additional health concerns will occur. In fact, eight out of ten people in the obesity category will have another health problem. Obesity is related to over 30 other diseases. This implies while the state obesity rates increase, other health problems such as diabetes, heart diseases, and certain types of cancer will also increase. Higher body weights are also associated with an increase in all-cause mortality.<sup>18</sup>

The following conditions increase with obesity:<sup>17</sup>

- Coronary heart disease
- Type 2 diabetes
- Cancers (endometrial, breast, and colon)
- Hypertension (high blood pressure)
- Dyslipidemia (high total cholesterol or high levels of triglycerides)
- Stroke
- Liver and gallbladder disease
- Sleep apnea and respiratory problems
- Osteoarthritis
- Gynecological problems (abnormal menses, infertility)

## **WEIGHT TRENDS**

Information from the Alabama Obesity Task Force Strategic Plan for the Prevention and Control of Overweight and Obesity in Alabama revealed alarming statistics about obese and overweight individuals. The prevalence of overweight and obesity has increased steadily and is at epidemic levels.

The 1999–2002 National Health and Nutrition Examination Survey (NHANES) results from using measured heights and weights have indicated that an estimated 65 percent of U.S. adults were either overweight or obese. Alabama has also experienced a steady increase in the rate of overweight and obesity. In 1995, the overweight and obesity combined categories were at 54.1 percent; and 13 years later the two categories had increased to 67.9 percent. It is with concern to note that the rate of obesity has increased at a greater speed than overweight.<sup>19</sup>

In 1995, Alabama had 18.7 percent of adults in the obesity category, and in 2009, the state average was 31.6 percent, with some counties as high as 43 percent. When obese categories are reviewed by race, income, and education, the groups with the highest rates of obesity in Alabama are African Americans, individuals who earn less than \$25,000 year, and those with



less than a high school diploma. It is interesting to note that the more recent years, 2007 and 2008, show the obesity rates becoming closer for those without high school diplomas to those with a diploma. An increase in obesity is also noted in those with two or less years of post high school education.<sup>16</sup>

Overall, approximately 70 percent of the adult population has weight concerns. The statistics listed below are related to nutrition and lifestyle behaviors that influence chronic conditions and mortality in Alabama, based on 2009 data.<sup>8</sup>

- In Alabama, only 19.6 percent of adults reported consuming five or more servings of fruits and vegetables a day versus the national average at 23.3 percent.
- Alabama was rated as the sixth highest for physical inactivity, with 58.9 percent of adults not having 30 plus minutes of moderate physical activity five or more days per week, and 78.9 percent not having vigorous physical activity for 20 plus minutes three or more days per week.
- Our youth are following adults' habits with only 16.3 percent eating the recommended five servings of fruit and vegetables a day and 37.3 percent being physically active for five or more days a week, as described in the YRBSS survey.<sup>9</sup>

The above trends indicate there is much need to address nutrition and physical activity behaviors in Alabama.



# T OBACCO

Tobacco use and exposure is the leading preventable cause of death in the United States. Tobacco kills more people than alcohol, HIV/AIDS, car crashes, illegal drugs, murders, and suicides combined. The Tobacco Prevention and Control (TPC) Branch within the ADPH Bureau of Health Promotion and Chronic Disease was created with funds from the Centers for Disease Control and Prevention (CDC) in 1993. The branch's mission is to improve the health of all Alabamians by working to prevent youth initiation of tobacco use, promote quitting among youth and adults, and eliminate exposure to secondhand smoke, while addressing tobacco-related disparities among Alabamians.

## Prevalence

The *2010 Tobacco Control Highlights for Alabama*, published by the CDC, offers the following data:<sup>21</sup>

- Across all states, the prevalence of cigarette smoking among adults ranges from 9.3-26.5 percent.
- In Alabama, 22.1 percent of the adult population (ages 18 and up) – more than 783,000 individuals - are current cigarette smokers. Alabama ranks number 42 among the states for adult smoking.
- Among youth ages 12-17 in Alabama, 12 percent smoke. The range across all states is 6.5-15.9 percent. Alabama ranks number 40 among the states for youth smoking.
- Alabama's smokeless tobacco rates are also above the national average. About 7.8 percent of adults use smokeless tobacco.
- According to the 2008 Alabama Youth Tobacco Survey (ALYTS), among the state's youth (grades 9-12), nearly 11 percent use smokeless tobacco.

## Mortality

The TPC Branch provides technical assistance and funding to all 11 public health areas and 13 youth serving organizations statewide. Funding for these state- and local-level programs is provided by the State of Alabama and the CDC.

Smoking-Attributable Adult (35+ years of age) Mortality is defined as the average total number of deaths among adults aged 35 years or older from 19 diseases caused by cigarette smoking in 2000-2004. The smoking-attributable mortality rate was calculated by dividing the number of smoking-related deaths by the adult (35+ years of age) population. The result is presented per 100,000 population.<sup>22</sup>

During 2000-2004, the CDC estimated over 7,600 adults per year, ages 35 and over, on average died as a result of tobacco use from annual smoking-attributable mortality.



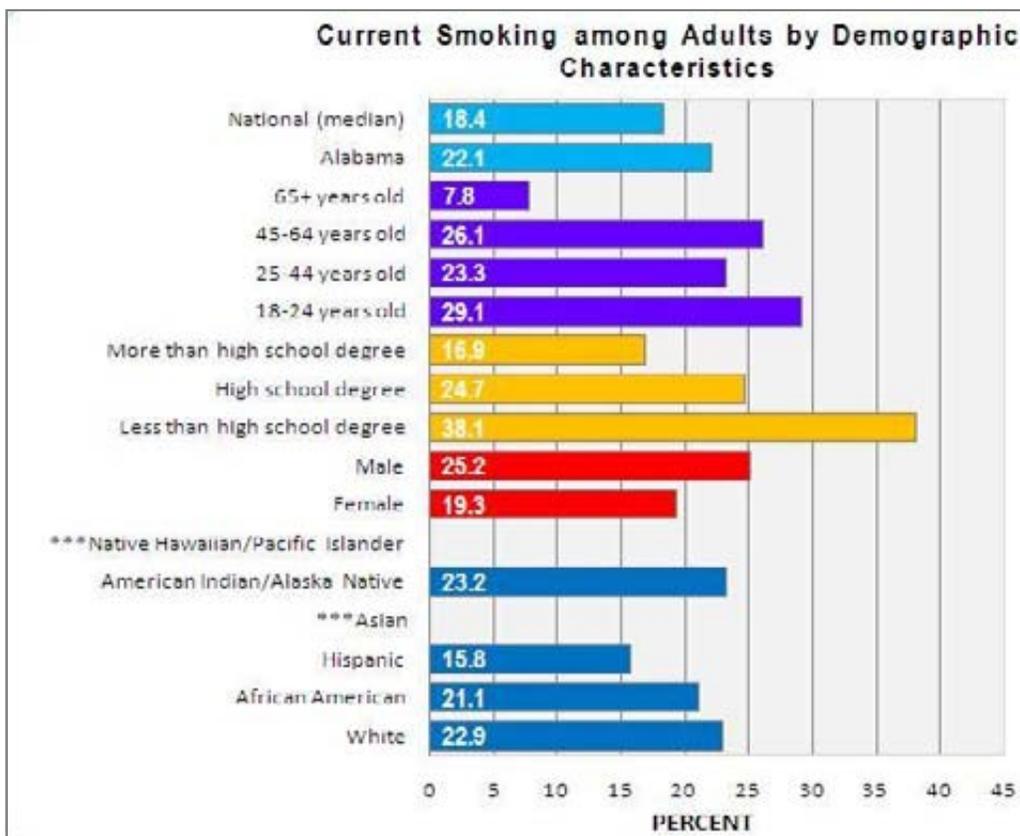
The smoking-attributable mortality rate was 317.5 per 100,000, and ranks Alabama's smoking-attributable mortality rate as number 44 among the states.<sup>24</sup>

## Disparity

Tobacco-related disparities in cigarette use have been identified based on gender, education level, race, and age. According to the BRFSS for Alabama in 2009, data include:<sup>23</sup>

- Adults with less than 12 years of education have smoking rates of 35.6 percent.
- Individuals with some post high school education had a rate of 23.9 percent versus college graduates having an 11.6 percent smoking rate.
- The percentage of smoking among Whites was 22.3 percent and 20.3 percent for African Americans.
- African American males have the highest smoking rates of 27.5 percent compared to White males at 24.6 percent.

## Figures



\*\*\*Data is not shown because sample size is less than 50.<sup>24</sup>



Quitting smoking provides many health benefits over time. To learn more about how to quit, call 1-800-QUIT-NOW (784-8669), or visit the website at: <http://www.adph.org/tobacco>, and click on the link in the left navigation on the page, “Alabama Tobacco Quitline.”

According to the 2009 BRFSS, Alabama adult everyday smokers data, 56.5 percent have tried to quit for one day or longer.<sup>8</sup>

Based on estimates from the past two years, it is anticipated that the Quitline will receive 1,000 calls per month for screening and initial services.

### Lifestyle

The following statistics are related to lifestyle behaviors that influence cancer incidence and mortality in Alabama:<sup>25</sup>

- In 2009, 25.7 percent of men and 19.7 percent of women reported current cigarette smoking.
- In 2008, 22.1 percent of Alabama high school students reported smoking cigarettes. The younger one begins smoking, the more likely one is to be an adult smoker.

One year after quitting, a person’s additional risk of heart disease is reduced by half, and after 15 years, this risk equals that of a person who never smoked.<sup>21</sup>

Five to 15 years after quitting smoking, the risk of stroke for an ex-smoker equals that of a person who never smoked.<sup>21</sup>

The risk of developing cancers of the mouth, throat, and esophagus lessen significantly after five years of quitting smoking.<sup>21</sup>



# CANCER

Comprehensive cancer control has been defined as an integrated and coordinated approach to reducing cancer incidence, morbidity, and mortality through prevention, early detection, treatment, and palliation. This comprehensive approach involves systematic assessment of state cancer concerns to ensure that important priorities are identified, resources are efficiently used, gaps in education and services are identified, and duplication of efforts is avoided.

The Alabama Comprehensive Cancer Control Coalition (ACCCC) is comprised of a diverse group of statewide organizations and partners who are committed to the reduction of the cancer burden.

## Incidence

In 2010, there will be an estimated 24,090 new cases (approximately 66 per day) of cancer diagnosed in Alabama. The following is a list of the estimated new cases of cancer diagnosed in 2009 for Alabama for selected cancer sites: 4,040 lung cancer; 2,480 colorectal cancer; 2,970 female breast cancer; 2,800 prostate cancer; 190 cervical cancer; and 930 cases of melanoma.<sup>31</sup>

For both genders combined, Alabama's cancer incidence rate is 454.7, which is lower than the U.S. rate of 472.9. Males in Alabama have a higher cancer incidence rate than females with a rate of 549.4 and 380.6, respectively. Black males have a higher cancer incidence rate than white males with a rate of 618.3 and 546.8. Among females, white females have a higher cancer incidence rate than black females with a rate of 386.7 versus 357.2.<sup>31</sup>

## Mortality

In 2010, there will be an estimated 9,900 deaths (approximately 27 per day) from cancer in Alabama making cancer the state's second leading cause of death following heart disease. The following is a list of the top five estimated deaths from cancer in 2009 in Alabama for selected cancer sites: 3,140 lung cancer; 940 colorectal cancer; 700 female breast cancer; 510 prostate cancer; and 550 deaths from pancreatic cancer.<sup>31,32</sup>

For both genders combined, Alabama's age adjusted cancer mortality rate is 205.1—higher than the U.S. rate of 195.7. Males in Alabama have a higher age adjusted cancer mortality rate than females with a rate of 271.6 versus 161.8. Among males, black males have a higher age adjusted cancer mortality rate than white males with a rate of 342.2 versus 257.4. Among females, black females have a higher age adjusted cancer mortality rate than white females with a rate of 175.7 versus 158.4.<sup>31</sup>



## Disparity

Significant disparities in cancer incidence and mortality are evident in minority and under-served population groups in the state.

From 1997-2006, African American men (59.3 per 100,000) had a 14.7 percent higher colorectal cancer incidence rate than White men (51.7 per 100,000).<sup>34</sup>

Compared to White females, breast cancer incidence rates are lower among African American women in Alabama, but the mortality rates are higher.<sup>52</sup>

Research shows African American men are more likely to develop prostate cancer and twice as likely to die from it than other races.<sup>29</sup>

## Figures

### CANCER MORTALITY BY RACE/ETHNICITY ALABAMA, 2000-2008<sup>42</sup>

	RACE	2000	2008	TOTAL PERCENTAGE CHANGE 2000-2008	STATUS	DISPARITY
Cancer	AFRICAN AMERICAN	242.6	227	-6.4	decreased	From 2000-2008, the African American rate decreased less than the White rate.
	WHITE	207.4	192.6	-7.1	decreased	

Age adjusted mortality rates are per 100,000 population.

To calculate a percentage change: Take the Old value (2000) and subtract from the New value (2008), then divide by the Old value (2000), and then multiply by 100. Formula= (2008-2000)/2000 x 100.  
The disparity is based on the rate ratio between African Americans and Whites. A rate ratio is calculated by dividing the African American Rate by the White Rate in a given year. The disparity is represented as a percentage.

## Tobacco and Smoking-Caused Cancer

Over 125,000 men and women die of smoking-caused lung cancer each year.

The following tobacco statistics influence cancer incidence and mortality in Alabama.<sup>28</sup>

- Compared to nonsmokers, men and women who smoke are approximately 23 and 13 times more likely to develop lung cancer, respectively.
- Lung cancer aside, 30 percent of all other cancer deaths are due to smoking.
- Smoking is a known cause of cancer of the lung, larynx, oral cavity, bladder, pancreas, uterus, cervix, kidney, stomach, and esophagus.



## Lung

Lung cancer is the deadliest type of cancer for both men and women. Lung cancer is more common in older adults. It is rare in people under age 45.<sup>20</sup>

Cigarette smoking is the leading cause of lung cancer.

Radon is the second leading cause of lung cancer in the United States, causing an estimated 22,000 deaths a year. High levels of indoor radon have been found in many areas of Alabama; however, it appears to occur most frequently in homes across the Tennessee Valley and in the foothills of the Appalachian Mountains, from Jefferson and Shelby to Cleburne Counties.<sup>26</sup>

## Colorectal

Colorectal cancer is an abnormal growth of cancer cells that occurs in the colon, the large intestine or large bowel, and/or the rectum. These abnormal cells form into pre-cancerous polyps called adenomas. If these polyps are not removed, they can later develop into colorectal cancer.

In Alabama, as in the U.S., colorectal cancer is the third most common cancer diagnosed for men and women and accounted for 8.7 percent of total cancer deaths in the state in 2007.<sup>26</sup>

If colorectal cancer is diagnosed at an early stage, it is more than 90 percent curable; however, 42 percent of cases in Alabama are diagnosed at stage 3 or 4, late stage.<sup>26</sup>

Most people should start screening tests at age 50. If there is a personal or family history of colon polyps or colorectal cancer, a person may need to start earlier with screening.

Colorectal cancer can be screened early with one of these procedures:

- High sensitivity gFOBT, iFOBT, or FIT annually.
- A flexible sigmoidoscopy every five years.
- A colonoscopy every ten years.

New technology makes screening affordable, easy, and convenient. Screening can be done at home by using fecal immunochemical tests. The fecal immunochemical test (FIT) and the immunochemical fecal occult blood test (iFOBT) are tests that detect hidden blood in the stool in the lower colon. If the results are positive, a colonoscopy is needed to investigate further. The FIT or iFOBT test must be repeated every year.<sup>26</sup>



## ***Breast***

Breast cancer is a malignant tumor that grows in one or both of the breasts. Breast cancer usually develops in the ducts or lobules, the milk producing areas of the breast.

Breast cancer is the second leading cause of cancer death in women (after lung cancer) causing 684 deaths in 2008. When breast cancer is detected early, there is a 97 percent survival rate.<sup>27</sup>

The Alabama Breast and Cervical Cancer Early Detection Program (ABCCEDP) was established by Title XV of the Public Health Services Act, known as the “Breast and Cervical Cancer Mortality Prevention Act of 1990” (Public Law 101-354). This program, funded through the CDC, is to prevent unnecessary disease, disability, and premature death due to cancer of the breast or cervix by providing early detection, screening, and referral services.

## ***Gynecologic: Cervical/Ovarian/Uterine***

Cervical cancer is almost 100 percent preventable through routine Pap tests.<sup>31</sup> In Alabama, cervical cancer is the third leading cause of gynecological cancer deaths, with 84 deaths in 2008. For prevention, it is recommended that women should have a routine gynecological exam.

Ovarian cancer is an alarming disease with a high mortality rate due to 70 percent of cases being diagnosed at an advanced stage. In the U.S., approximately 23,300 cases are diagnosed annually, resulting in 13,900 deaths per year. In Alabama, ovarian cancer remains the leading cause of gynecologic cancer deaths, with 280 deaths in 2008.<sup>31</sup>

Uterine cancer (also called Endometrial cancer) develops in the endometrium, the lining of the uterus, or womb, an important female reproductive organ. There are different types of uterine cancer. Cancer of the uterus occurs mostly in women over age 50.<sup>37</sup>

## ***Pancreatic***

Pancreatic cancer is the fourth leading cause of cancer death in the United States. Substantial evidence indicates that tobacco smoking, adult onset diabetes, and impaired glucose tolerance increase the risk for pancreatic cancer.

Some studies have also shown that obesity and physical inactivity (both factors strongly linked to abnormal glucose metabolism) and higher consumption of red and processed meat are associated with elevated pancreatic cancer risk, and that fruit and vegetable intake is associated with reduced risk, but none of these relationships are yet firmly established.

At the present time, the best recommendations to reduce the risk of pancreatic cancer are to avoid tobacco use, maintain a healthful weight, remain physically active, and eat five or more servings of vegetables and fruits each day.<sup>36</sup>



## Prostate

Prostate cancer is the most common cancer among men, excluding skin cancer. All men are at risk for prostate cancer. Family history and age are both factors that increase the risk. African-American men are more than twice as likely to contract prostate cancer, and it is nearly twice as likely to be fatal when compared to White men.<sup>29</sup> It is recommended for men ages 50 and older to discuss prostate screening with their health care provider. Men who are at a higher risk for prostate cancer are encouraged to start testing at age 45.<sup>35</sup>

The main risk factors include:

**Age**—Prostate cancer is more common as men get older.

**Race or Ethnicity**—For reasons that are not well understood, African American men have a higher risk of developing and dying of prostate cancer, compared to White or Hispanic and Latino men. Prostate cancer is less common among Asian/Pacific Islanders and American Indian/Alaskan Indian men.

**Family History**—If there is a family history of prostate cancer, the chances of developing prostate cancer is higher. Multiple relatives or close relatives who were diagnosed with prostate cancer at a young age have an increased risk.

**Diet**—A high fat diet and obesity may increase the risk of prostate cancer.

The most recent estimates for prostate cancer in Alabama are:

- The prostate cancer death rate in Alabama is 38 per 100,000, three over the national average, while only 50 percent of men over 50 get screened for the disease annually (the national percentage is 52.3)<sup>32</sup>
- Prostate cancer is the second leading cause of cancer death among Alabama men causing 520 deaths in 2008 for a crude rate of 38 per 100,000 (Lung cancer is the first).<sup>31</sup>
- One man in six will get prostate cancer during his lifetime.
- One man in 35 will die of this disease.<sup>27</sup>

## Melanoma

Melanoma skin cancer has become the most common cancer in the United States. In 2007, the American Cancer Society estimated that 59,940 new cases of melanoma would be diagnosed, and that 8,110 deaths would result from this cancer.<sup>27</sup>

- In Alabama, 7,855 cases of melanoma were diagnosed from 2004-2008.
- From 2004-2008, 92.8 percent of melanoma cases were diagnosed as Early Stage; however, males were more likely to be diagnosed at Late Stage.



## ***Screening/Early Detection Goals***

Screening tests offer a powerful opportunity for the detection and successful treatment of many cancers, sometimes before they are even considered cancer. Detection of disease in an early or asymptomatic stage greatly improves available treatment options for many cancers and increases the likelihood for cure.<sup>26,27</sup>

Breast, cervical, and colorectal cancers have effective screening tests that can find cancer early; however, further research about the effectiveness of screening for prostate cancer is needed. Men will need to be able to make informed decisions regarding the risks and benefits associated with prostate cancer screening and treatment. Health care professionals play an important role by providing information about cancer screening services and by encouraging their patients to participate in routine screening procedures.<sup>26</sup>

## ***Prevention/Recommendations***

### **Lifestyle**

Individuals' lifestyle choices will be the health focus for the 21st century. Peer education, community-based interventions, and better access to preventive care will help Alabamians make better lifestyle choices and help the state continue to make progress in the battle against cancer. To decrease cancer incidence and mortality rates, Alabamians are encouraged to modify their lifestyle choices.

- Eat healthy
- Drink alcohol in moderation
- Obtain regular cancer screenings
- Protect skin from UV radiation
- Practice safe sex
- Obtain a Human Papillomavirus Virus (HPV) vaccination, females ages 9-26
- Exercise regularly
- Maintain a healthy body weight
- Be tobacco free
- Stop using tanning beds and artificial lights



### Community Action Recommendations

- Public, private, and community organizations should work to create social and physical environments that support the adoption and maintenance of healthful nutrition and physical activity behaviors.
- Increase access to healthful foods and nutritional information in schools, worksites, and communities.
- Provide safe, enjoyable, and accessible environments for physical activity in schools, and for transportation and recreation in communities.
- Provide adequate shade for school playgrounds.
- Encourage sun block usage for athletes and during outdoor events.
- Encourage sun block usage for day care and school children at recess and play.
- Eliminate access to tanning beds for minors.
- Eliminate secondhand smoke and indoor smoking exposure.



# CARDIOVASCULAR DISEASE

Cardiovascular disease (CVD) refers to conditions and diseases of the heart and blood vessels and includes coronary artery disease, angina, heart attack, stroke, high blood pressure, and congestive heart failure. Heart disease has been the leading cause of death in the United States since 1921, and stroke has been the third leading cause since 1938; together they account for approximately 40 percent of all deaths.

The Cardiovascular Health Program works to raise awareness to improve the quality of heart disease and stroke care and facilitate change in high risk communities in Alabama no matter one's race, ethnicity, gender, geography, or socioeconomic status.

## Incidence

Heart disease deaths and death rates in Alabama in 2008 were 12,091, with 259.4 per 100,000.<sup>33</sup>

## Mortality

In Alabama, as in the nation, CVD, including heart disease and stroke, is the leading cause of death. Nationally, Alabama has the fourth highest death rate from heart disease and the seventh highest from stroke. In 2008, CVD accounted for 25.4 percent of all deaths, down from 28.6 percent in 2002.<sup>33</sup>

Death and disability from CVD is especially sobering since we know that much of heart disease and stroke can be prevented. The greatest opportunity for reducing CVD lies in prevention of the risk factors and conditions which lead to CVD. According to the American Heart Association, if all forms of major CVD were eliminated, the life expectancy of Americans would increase by almost ten years.<sup>33</sup>

## Disparity

Nationally, a large study of gender and racial disparities found that 76 percent of White men and 71 percent of White women had blood pressure controlled to an optimal level, while 63 percent of both African American men and women had blood pressure optimally controlled.<sup>17</sup>

## Lifestyle

The major modifiable risk factors for stroke are high blood pressure, smoking, high cholesterol, physical inactivity, and overweight/obesity. By making lifestyle changes to lower cholesterol by eating foods low in saturated fat and cholesterol; by losing weight when needed; by increasing physical activity; and by lowering the blood cholesterol level, individuals can cut their risk for heart disease and stroke.<sup>18</sup>

The Alabama Cardiovascular Health (CVH) Program receives funding from the CDC to develop and coordinate basic CVD program functions and activities. The CDC provides guidance to the CVH Program to work in three settings: communities, worksites, and health care.



Within these settings, the CVH Program works to carry out the objectives listed in the Alabama Cardiovascular State Plan and the CDC’s program priority areas:

- Increase control of high blood pressure.
- Increase control of high blood cholesterol.
- Increase knowledge of signs and symptoms for heart attack and stroke and the importance of calling 9-1-1.
- Improve emergency response.
- Improve the quality of heart disease and stroke care.
- Eliminate disparities in terms of race, ethnicity, gender, geography, or socioeconomic status.

## Figures

### HEART DISEASE MORTALITY RATES BY RACE/ETHNICITY ALABAMA, 2000-2008<sup>42</sup>

	RACE	2000	2008	TOTAL PERCENTAGE CHANGE 2000–2008	STATUS	DISPARITY
Heart Disease	AFRICAN AMERICAN	445.8	370.7	-16.8	<b>decreased</b>	The disparity has worsened from 18% higher in 2000 for African Americans to 24% higher in 2008 when compared to Whites.
	WHITE	375.4	298.0	-20.6	<b>decreased</b>	

Age adjusted mortality rates are per 100,000 population.

To calculate the rate/percentage change: Take the Old value (2000) and subtract from the New value (2008), then divide by the Old value (2000), and then multiply by 100. Formula=  $(2008-2000)/2000 \times 100$ .

The disparity is based on the rate ratio between African Americans and Whites. A rate ratio is calculated by dividing the African American Rate by the White Rate in a given year. The disparity is represented as a percentage.

## Stroke

Stroke, or cerebrovascular disease, occurs when a blood vessel going to the brain is disrupted either by a blood clot or a ruptured vessel. Stroke is a leading cause of long-term disability in the United States.<sup>17</sup>

### Mortality

Alabama ranks fourth in the nation in deaths due to stroke.

- More than 37 percent (37.1) of Alabama citizens have high blood pressure.
- High blood pressure, also called hypertension, increases the risk for heart disease and stroke, two of the leading causes of death in Alabama.
- A person’s risk of heart disease and stroke rises as blood cholesterol levels increase.



## **CARDIOVASCULAR DISEASE—Men**

### **Prevalence**

The prevalence among males was significantly higher than for females in Alabama.

### **Mortality**

Men have a higher age-adjusted heart mortality rate, 268.6 per 100,000 men, than women, 240.4 per 100,000 women.

Coronary heart disease, the most common type of heart disease, can result in heart attack, which can be prevented by modifying risk factors.<sup>17</sup>

### **Disparity**

- In 2008, the mortality rate for heart disease was highest among black males with a rate of 226.6 per 100,000 population.<sup>33</sup>
- In 2008, black males showed the highest stroke death rate of 58.0 per 100,000 population.<sup>33</sup>

### **Lifestyle**

Overweight and obese individuals are more likely to have risk factors for heart disease and stroke, and in Alabama, 65.8 percent of adults are overweight and obese.<sup>33</sup>

It is recommended to check cholesterol levels regularly starting at age 35. Individuals younger than 35, should talk to their doctor about whether to have their cholesterol checked.

Risk factors may include:

- Diabetes
- High blood pressure
- Family history of heart disease
- Tobacco use

Smoking more than doubles the risk for heart disease and stroke, and 22.5 percent of adults are current smokers. Physical inactivity also increases the risk for heart disease and stroke, and 16.9 percent of adults were physically inactive. Reduced consumption of fresh fruits and vegetables increases the risk for heart disease and stroke, and only 19.6 percent of adults met the recommended daily requirements of fruits and vegetables consumption.

Risk awareness, risk reduction, and early access to medical care can reduce health disparities and result in individuals at-risk having healthier, longer lives.



## **CARDIOVASCULAR DISEASE—Women**

### **Prevalence**

- More than one-third (36.6 percent) of Alabama women have been diagnosed with high blood pressure.<sup>8</sup>
- More than 38 percent (38.6) of Alabama women have been told by a health professional they tested positive for high cholesterol.<sup>8</sup>
- Overweight and obesity increased with an increase in age, with a significant increase from the 18-24 to the 25-34 age group.<sup>18</sup>

### **Mortality**

Heart disease is the number one cause of death of all women in Alabama. African American and Hispanic women have disproportionately high rates of heart disease.<sup>52</sup>

In 2008, black females had a stroke death rate of 63.1 per 100,000 population.<sup>52</sup>

### **Disparity**

African Americans reported having a higher prevalence of being overweight and obese compared to Whites in 2009.<sup>18</sup> In 2009, 78.7 percent of Alabama African American women were overweight and obese compared to 67.4 percent of Alabama White women.<sup>8</sup>

### **Lifestyle**

Thirty-two percent of Alabama women identify themselves as obese.

- In 2009, 19.7 percent of Alabama women smoked, and only 21.5 percent reported consuming five plus fruit and vegetable servings each day.<sup>33</sup>

Major health risk factors such as overweight, sedentary lifestyles, high blood pressure, and high cholesterol levels contribute markedly to the development of heart disease. To decrease the chances of heart disease, women should:

- Eat a healthy diet, including five or more fruit and vegetable servings daily.
- Reduce sodium consumption.
- Increase physical activity, such as brisk walking at least 30 minutes on five or more days of the week.
- Take steps to reduce stress.
- Control weight.
- Control high blood pressure.
- Control cholesterol.
- Be tobacco free.
- See a physician regularly.



# D IABETES

The American Diabetes Association reports that more than 24 million people in the United States have diabetes. At least 57 million people in the United States have what is referred to as “pre-diabetes.” Overweight and inactive individuals increase their risk of developing Type 2 diabetes.<sup>8</sup>

## Prevalence

In Alabama, more than one adult in ten has been diagnosed with diabetes. Alabama is ranked fifth in prevalence of diabetes in the United States and its territories. The following data relates to the prevalence of diabetes in Alabama:<sup>18</sup>

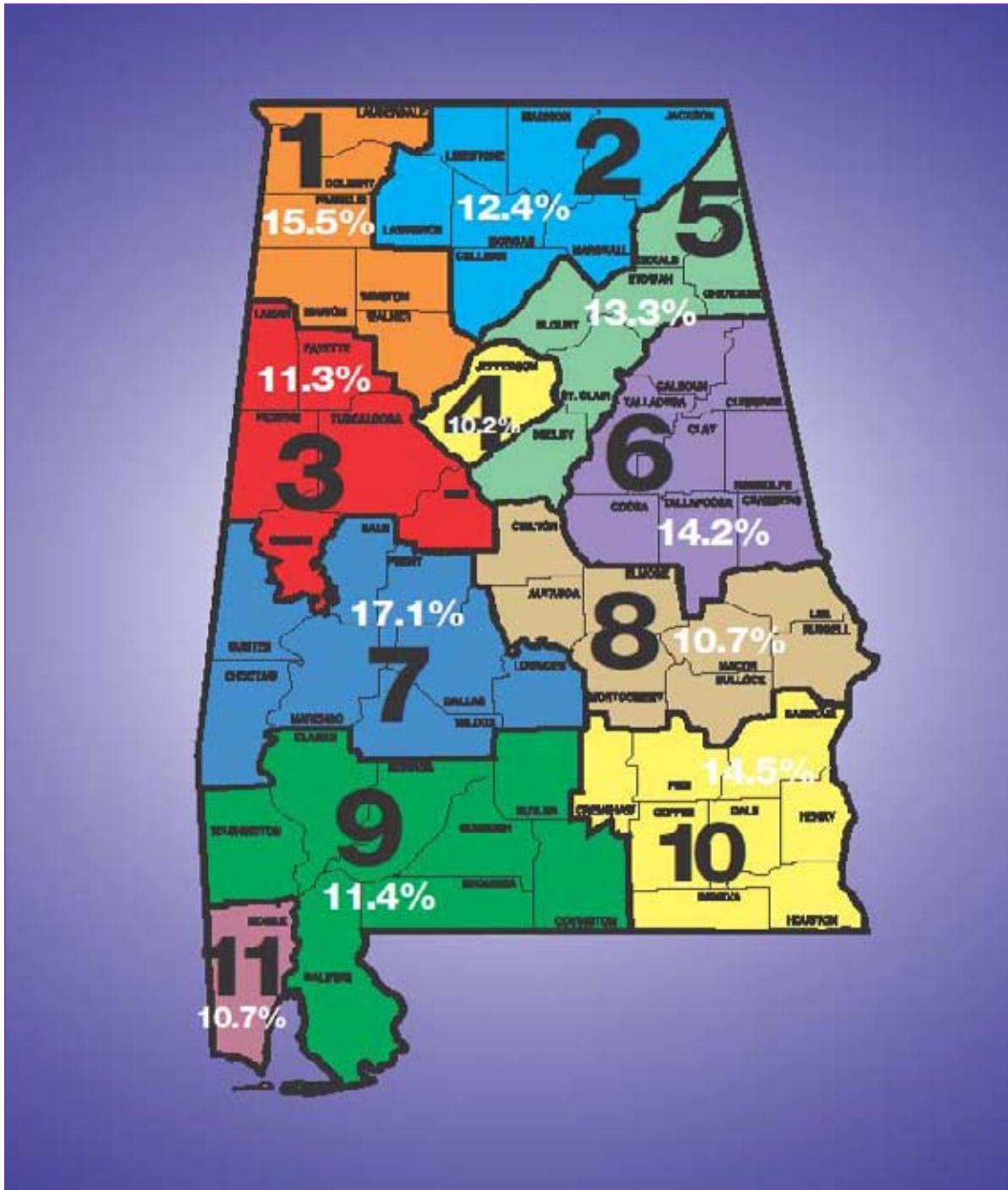
- Based on the 2009 BRFSS data, approximately 434,800 people in Alabama are aware they have diabetes.<sup>8</sup>
- As many as 200,000 more may have diabetes and do not know they have diabetes.<sup>8</sup>
- Increased prevalence of Type 2 diabetes is now common in younger populations.<sup>8</sup>
- Diabetes prevalence increases with age. The proportion of persons aged 45 to 64 reporting diabetes is approximately 4.5 times higher than the proportion of persons aged 18 to 44.<sup>8</sup>
- The prevalence of diabetes is very similar among men (13.0 percent) and women (11.5 percent) in Alabama.<sup>8</sup>

Public Health Area	Counties in Public Health Area	Diabetes Prevalence
		<b>2009</b>
1	Colbert, Franklin, Lauderdale, Marion, Winston, and Walker	15.5%
2	Cullman, Jackson, Lawrence, Limestone, Madison, Marshall, and Morgan	12.4%
3	Bibb, Fayette, Greene, Lamar, Pickens, and Tuscaloosa	11.3%
4	Jefferson	10.2%
5	Blount, Cherokee, DeKalb, Etowah, Shelby, and St. Clair	13.3%
6	Calhoun, Chambers, Clay, Cleburne, Coosa, Randolph, Talladega, and Tallapoosa	14.2%
7	Choctaw, Dallas, Hale, Lowndes, Marengo, Perry, Sumter, and Wilcox	17.1%
8	Autauga, Bullock, Chilton, Elmore, Lee, Macon, Montgomery, and Russell	10.7%
9	Baldwin, Butler, Clarke, Conecuh, Covington, Escambia, Monroe, and Washington	11.4%
10	Barbour, Coffee, Crenshaw, Dale, Geneva, Henry, Houston, and Pike	14.5%
11	Mobile	10.7%
	<b>STATE</b>	<b>12.3%</b>

# DIABETES



Alabama Department of Public Health/Area Diabetes Current (2009) Prevalence\*<sup>8</sup>



\*Estimates calculated from collected data using the 2009 BRFSS State Average: 12.3 percent.



In diabetic patients, health care provision and self monitoring are very important. The various perceptions of providers and patients around health care in addition to cultural norms can play a vital role in medical provision of care and patient compliance. The following data from 2008 and 2009 reflects differences among African Americans and Whites.

**Physician Completed Screenings In 2009<sup>8</sup>**

Flu Shot	White	62.6 percent	African American	52.3 percent
Eye Exam	White	79.5 percent	African American	81.6 percent
Foot Exam	White	64.6 percent	African American	75.1 percent
HbA1c Test	White	63.5 percent	African American	50.8 percent

**Patient Completed Actions In 2008<sup>8</sup>**

Daily Foot Check	White	68.5 percent	African American	76.6 percent
Daily Blood Check	White	62.4 percent	African American	66.7 percent

**Mortality**

In Alabama, diabetes accounts for approximately three percent of deaths. In 2008, the overall diabetes mortality rate was 29.6 per 100,000. In 2008, this meant that diabetes was the documented cause of death for some 1,380 Alabama citizens. While the mortality associated with diabetes is increasing and the national rates seem to be stabilizing, Alabama’s diabetes mortality rate continues to climb.<sup>8</sup>

**Disparity**

A particular concern is the disparity that exists in diabetes mortality in Alabama by race. The diabetes mortality rate for Whites was 25.4 per 100,000. The diabetes mortality rate for African Americans was approximately 43.3 per 100,000, 70 percent higher than the White rate. The prevalence of diabetes among African Americans is higher than the prevalence of diabetes among Whites within every age group. Diabetes is also the leading cause of end-stage renal disease (ESRD). Diabetes contributes to high blood pressure, stroke, kidney disease, blindness, lower extremity amputations, depression, and other complications.<sup>8</sup>

# DIABETES



## Figures

### DIABETES MORTALITY RATES BY RACE/ETHNICITY ALABAMA, 2000-2008<sup>42</sup>

	RACE	2000	2008	TOTAL PERCENTAGE CHANGE 2000-2008	STATUS	DISPARITY
Diabetes	AFRICAN AMERICAN	53.5	53.1	-0.7	decreased	The disparity has worsened from 132% higher in 2000 for African Americans to 154% in 2008 when compared to Whites.
	WHITE	23.1	20.9	-9.5	decreased	

**Age Adjusted** mortality rates are per 100,000 population.

To calculate the rate/percentage change: Take the Old value (2000) and subtract from the New value (2008), then divide by the Old value (2000), and then multiply by 100. Formula=  $(2008-2000)/2000 \times 100$ .

The disparity is based on the rate ratio between African Americans and Whites. A rate ratio is calculated by dividing the African American Rate by the White Rate in a given year. The disparity is represented as a percentage.

### DIABETES MORBIDITY/MORTALITY RATES BY RACE ALABAMA, 2000-2008

RACE	2000	2008	TOTAL PERCENTAGE CHANGE 2000-2008	STATUS	DISPARITY
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#### DIABETES DEATH RATE

TOTAL POPULATION	29.6	29.6	0	same	The disparity has worsened from 58% higher in 2000 to 70% higher in 2008 for African Americans when compared to Whites.
AFRICAN AMERICAN	41.6	43.3	-4.1	increased	
WHITE	26.3	25.4	-3.4	decreased	

\*To calculate the rate/percentage change: Take the Old value (2000) and subtract from the New value (2008), then divide by the Old value (2000), and then multiply by 100. Formula=  $(2008-2000)/2000 \times 100$ . The disparity is based on the rate ratio between African Americans and Whites. A rate ratio is calculated by dividing the African American Rate by the White Rate in a given year. The disparity is represented as a percentage.



## ***Prevention/Recommendations***

### **Lifestyle**

Weight loss and physical activity in moderation can help prevent Type 2 diabetes. Physical activity can be found in common activities such as walking, bike riding, housework, and yard work. By adding more activities to the daily routine, individuals can increase activity and help improve health.

Proper nutrition is essential in the prevention of diabetes. The major modifiable risk factors are physical inactivity, obesity/overweight, and smoking.

Alabamians are encouraged to implement health systems changes, community interventions, and health communication programs to improve the prevention and treatment of diabetes in their communities. Individuals may attempt to make changes such as:

- Lose five to ten percent of your body weight and maintain a healthy weight.
- Be physically active 30-60 minutes of moderate to vigorous physical activity five days a week.
- For healthy meals, restrict calorie intake, increase fiber, and limit carbohydrates.
- Control blood pressure.
- Lower sodium (salt) intake.
- Know the risk factors.
- Know the signs and symptoms.
- Know the complications of diabetes.
- See your health care provider for pre-diabetes and diabetes screening.
- If you are Medicare eligible, ask your health care provider for the free screening for pre-diabetes and diabetes.



# HIV/AIDS

Human Immunodeficiency Virus (HIV) is a virus that weakens the body's defense (immune) system until it can no longer fight off illnesses such as pneumonia, tuberculosis, cancerous tumors, and others. HIV kills the CD4 cells (T cells), which direct the body's immune system to defend against infection.<sup>40</sup>

Acquired Immunodeficiency Syndrome (AIDS) occurs when the immune system is seriously damaged by HIV. In the U.S., an HIV-infected person receives a diagnosis of AIDS when his or her CD4 count is less than 200, or if diagnosed with a specific illness. (An average CD4 cell count in a healthy person is 1,150.)<sup>40</sup>

## Incidence

Cases reported to the Alabama Department of Public Health as of July 1, 2009:

- 6,769 Human Immunodeficiency Virus (HIV) infections and
- 9,417 Acquired Immune Deficiency Syndrome (AIDS)

A combined total of HIV/AIDS reported cases in Alabama are 16,186.<sup>8</sup> In Alabama:

- Females represented 30 percent of diagnosed HIV/AIDS cases. The highest proportion of new cases diagnosed were among females ages 25-34 years (31 percent), and ages 35-44 years (23 percent).
- Heterosexual contact (88 percent) and injection drug use (9 percent) represented the risk exposure for the majority of the females diagnosed with HIV/AIDS in 2008.<sup>8</sup>

## Mortality

In the United States, every nine-and-one-half (9½) minutes, someone is infected with HIV.<sup>40</sup>

## Disparity

- African American males represent 26 percent of the state's population; however, 63.8 percent (10,548) of all reported HIV/AIDS in Alabama are from this group.<sup>42</sup>
- African American females represent 19.2 percent (3,183) of all HIV/AIDS reported.<sup>42</sup>
- HIV/AIDS cases in African American males are reported in these risk factor categories:<sup>40</sup>
  - ▶ Men Who Have Sex with Men-MSM (36.3 percent)
  - ▶ Injecting Drug Use-IDU (12.7 percent)
  - ▶ Heterosexual (34.2 percent)
  - ▶ MSM/IDU (4.9 percent)
  - ▶ Maternal Transmission (1.0 percent), Transfusion (0.1 percent) Hemophilia (0.2 percent), and Undetermined (16.73 percent)



## HIV MORTALITY RATES BY RACE/ETHNICITY ALABAMA, 2000-2008<sup>42</sup>

	RACE	2000	2008	TOTAL PERCENTAGE CHANGE 2000-2008	STATUS	DISPARITY
<b>HIV/AIDS</b>	AFRICAN AMERICAN	13.9	11.6	-16.5	<b>decreased</b>	The disparity has improved from 769% higher in 2000 for African Americans to 729% higher when compared to Whites.
	WHITE	1.6	1.4	-12.5	<b>decreased</b>	
Age adjusted mortality rates are per 100,000 population.						
To calculate the rate/percentage change: Take the Old value (2000) and subtract from the New value (2008), then divide by the Old value (2000), and then multiply by 100. Formula= (2008-2000)/2000 x 100.						
The disparity is based on the rate ratio between African Americans and Whites. A rate ratio is calculated by dividing the African American Rate by the White Rate in a given year. The disparity is represented as a percentage.						

### Lifestyle

Efforts are being targeted to high-risk groups like African Americans, who make up just a tenth of the population, yet they account for nearly half of new HIV infections.<sup>8</sup>

#### As individuals:

- Get tested for HIV infection.
- If infected, seek medical care and protect others from becoming infected.
- Protect and educate yourself and others from HIV.

#### As communities:

- Mobilize to overcome the challenges and barriers to HIV prevention.
- Fight ignorance and complacency related to HIV.
- Increase the awareness about the severity of the epidemic and the continued impact that HIV is having on our communities.
- Make sure that HIV prevention services, HIV testing, medical care, and treatment are available to all who need them.
- Work to prevent stigma and discrimination—and to increase support for people living with HIV.

#### As a nation:

- Implement the programs that scientific evidence shows as being most effective.
- Ensure that those who need effective prevention interventions have access to them.
- Come together to intensify efforts and stop this epidemic.<sup>40</sup>



## ***HIV/AIDS—The South***

The document, *Southern States Manifesto: Update 2008*, was developed by the Southern AIDS Coalition (SAC) to increase national focus on the HIV/AIDS crisis in this region.<sup>41</sup>

The SAC believes that everyone who is HIV-positive or has any form of sexually transmitted disease has a right to access a range of health care and necessary support services to achieve and maintain optimal health regardless of gender, sexual orientation, geographic location, economic condition, race, or social status.

Among the findings released in the Manifesto at a news conference on July 21, 2008, were:<sup>41</sup>

- Throughout the rest of the country from 2001 to 2005, the number of deaths from AIDS decreased, but continued to increase in the South.
- Of the 15 states with the highest rates of new HIV infections, nine (60 percent) are in the South.
- Additionally, of the 20 metropolitan areas with the highest AIDS case rates in 2006, 16 (80 percent) are in the South. The South leads the nation in AIDS cases and rates in cities of all sizes.
- Over half (52 percent) of African Americans living with AIDS and 58 percent of new AIDS cases reported in 2006 among African Americans occurred in the South; yet, African Americans represent approximately 19 percent of the South's population.
- The South has the highest number of adults and adolescents living with and dying from AIDS in the United States.
- Through 2006, 52 percent of the reported, estimated, living HIV cases, and 41 percent of the reported, estimated, living AIDS cases were from the South.
- Prevention and treatment of HIV/AIDS are further complicated by the high prevalence of HIV-infected individuals living in rural areas. Southern states comprise 65 percent of all AIDS cases among rural populations.
- Only 36 percent of the U.S. population lives in the South. However, 40 percent of all people living with AIDS and 46 percent of newly identified cases now live in the southern states region.
- The South receives less federal funding and private funding than do states in other regions.

The first Alabama resident was diagnosed with HIV/AIDS in 1982. In November 1987, the Alabama Board of Health designated HIV as a reportable condition, and physicians became required to report diagnosed cases of AIDS. Until 1990, the ADPH had very limited participation in the provision of direct care services to persons infected with HIV/AIDS. With the receipt of Ryan White funding in 1991, a Direct Care Services Branch was organized to assume responsibility for all direct patient services and drug reimbursement.



## **I**NFANT MORTALITY

Infant mortality is defined as death occurring before the first birthday and is an important indicator of social, political, health care delivery, and medical outcomes in a geographic area. Infant deaths can be further classified into neonatal (0-27 days) and post neonatal (28-365 days) periods. Neonatal mortality is typically associated with events surrounding the prenatal period and the delivery whereas post neonatal deaths are more likely to be associated with conditions or events that arise after the delivery and may reflect environmental factors.<sup>45</sup>

### **Incidence**

Alabama's State Perinatal Program and the Office of Minority Health work to reduce the health disparity of infant mortality by implementing strategies that impact the Healthy People 2010 objective for infant mortality, which is the reduction in infant deaths to no more than 4.5 live births per 1,000.

Factors contributing to infant deaths include:

- Birth preterm (prematurity)
- Birth defects
- Low birthweight
- Births to teens
- Smoking and drug use during pregnancy
- No health insurance or underinsured<sup>45</sup>

### **Mortality**

Alabama's infant mortality rate (IMR) decreased from 9.5 infant deaths per 1,000 live births in 2008 to 8.2 in 2009.<sup>45</sup> The current rate of 8.2 will cause Alabama to be one of the states that lead the nation in infant mortality, although this is the lowest rate ever recorded.<sup>45</sup>

- In 2009, 513 infants died before reaching their first birthday.<sup>42</sup>
- In 2009, 61.8 percent of infant deaths occurred in the neonatal period and 38.2 percent occurred in the post neonatal period.

An additional troubling number is low birth weight (LBW) infants.

- In 2009, 10.4 percent of all live births were below 2,500 grams.
- Infants of low birthweight had an infant mortality rate of 55.2 in 2009, while normal weight infants had a 2.7 infant mortality rate. These very small babies are at risk for developing major long-term physical and cognitive problems with consequences that impact families and state resources.<sup>48</sup>



### Disparity

- Alabama's African American infant mortality decreased from a rate of 14.1 (per 1,000 live births) in 2008 to 13.3 per 1,000 live births in 2009, the lowest it has ever been, and it was very close to the 2007 national rate for blacks at 13.2.
- White infant mortality decreased from a rate of 7.6 in 2008 to 6.2 in 2009, also the lowest in history. The white rate continued to be above the national average of 6.5 in 2009.
- Infant mortality for Hispanic infants decreased from 8.9 in 2008 to 5.3 in 2009, a 40 percent decrease.
- In 2009, the infant mortality rate due to prematurity/low birth weight was 55.2 deaths per 100,000 live births.
- Prematurity/low birth weight accounted for 10.4 percent of all infant deaths in Alabama in 2009.<sup>48,49,50</sup>

### Figures

#### INFANT MORTALITY RATES\* BY RACE/ETHNICITY ALABAMA, 2000-2008<sup>42</sup>

	RACE	2000	2008	TOTAL PERCENTAGE CHANGE 2000-2008	STATUS	DISPARITY
*Infant Mortality	AFRICAN AMERICAN	15.4	14.1	-8.4	decreased	The disparity has improved from 137% in 2000 to 86% in 2008 between African Americans and Whites.
	WHITE	6.5	7.6	16.9	increased	

\*Rates are per 1,000 live births.

To calculate the rate/percentage change: Take the Old value (2000) and subtract from the New value (2008), then divide by the Old value (2000), and then multiply by 100. Formula= (2008-2000)/2000 x 100.  
The disparity is based on the rate ratio between African Americans and Whites. A rate ratio is calculated by dividing the African American Rate by the White Rate in a given year. The disparity is represented as a percentage.

### Low/Very Low/Extremely Low Birth Weight

Birthweight is a significant factor directly related to infant morbidity and the infant mortality rate. Babies born too soon or too small have a probability for significant risks of serious morbidity. Very low birthweight (under 3 pounds, 5 ounces) infants accounted for 286 of the 513 infant deaths in 2009. Low birthweight babies are medically fragile at birth and many become critically ill. Babies that survive usually require weeks of medical treatment for life-threatening conditions or infections.

Medical care provided in the Neonatal Intensive Care Units (NICU) has had a positive impact on neonatal mortality; however, the very low and extremely low birthweight survivors are vulnerable to critical illness during the post-neonatal period and many require hospital readmission. Over one-third of the total infant deaths occur in the post-neonatal period.<sup>45</sup>



The definitive causes of prematurity remain unknown; however, the increasing magnitude of the problem has gained attention of medical researchers and scientists. One of the current measures that can reduce prematurity is prevention of unintended pregnancies in women who have experienced a previous preterm birth. The probability of preterm birth is 30 percent greater for a woman who has had one previous premature infant and the risk increases to 70 percent for two or more previous preterm births.<sup>45</sup>

## Preterm (Premature) Birth

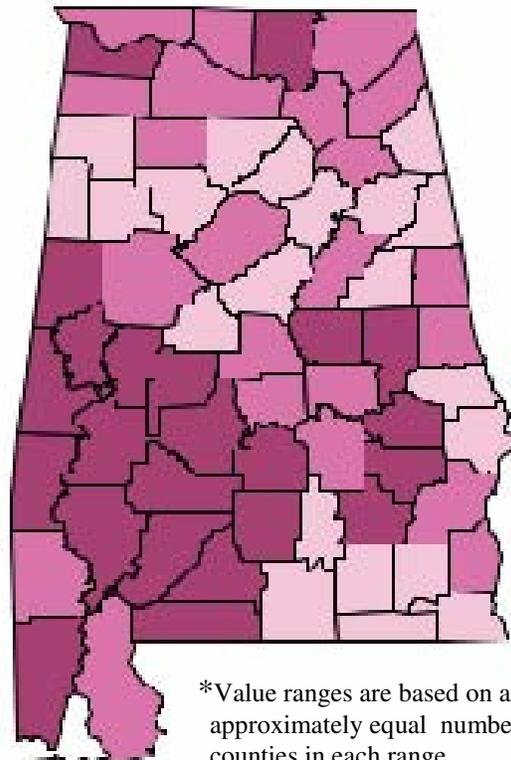
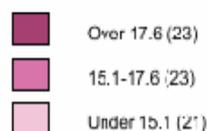
Preterm birth is defined as a live birth before 37 completed weeks of gestation. Some other classifications of preterm births include late preterm (34-36 weeks), moderately preterm (32-36 weeks) and very preterm (<32 weeks). These classifications are useful because they often correspond to clinical characteristics, resulting in increasing morbidities or illnesses with decreasing gestational age.

Babies born too soon are often born too small. While the causes of preterm birth and low birth weight may be different in some cases, there is significant overlap within these populations of infants.<sup>45</sup>

- In 2006, one in six babies (17.1 percent of live births) was born preterm in Alabama.
- Between 1996 and 2006, the rate of infants born preterm in Alabama increased 23 percent.
- The rate of preterm birth in Alabama is highest for African American infants (21.7 percent), followed by Native Americans (18.8 percent), Hispanics (14.6 percent), Whites (14.5 percent), and Asians (13.1 percent).<sup>48</sup>

### Map - Preterm Birth Rates, 2003-2006: Average percent of live births (67 Alabama Counties)<sup>42</sup>

- In Alabama in 2006, 81.7 percent of live births were to women receiving early prenatal care, 13.8 percent were to women beginning care in the second trimester, and 4.5 percent were to women receiving late or no prenatal care.



\*Value ranges are based on an approximately equal number of counties in each range.

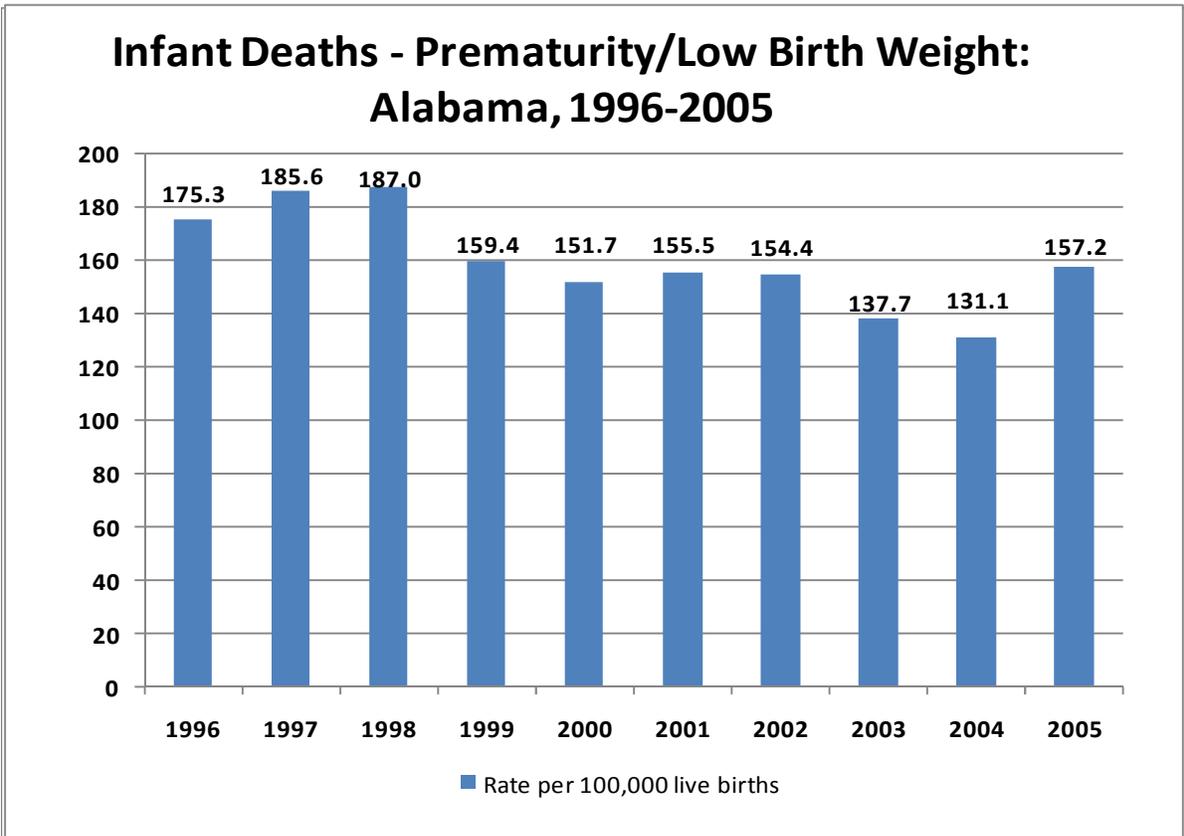


The following subsections within the Infant Mortality Section provide a description of the health, lifestyle, and social and economic conditions which often are factors that can be attributed to health disparities which affect multi-cultural populations in Alabama.

### ***Babies Born Too Small and Too Soon***

During an average week in Alabama:

- 207 babies are born preterm.
- 127 babies are born low birthweight.
- 36 babies are born very preterm weight.
- 24 babies are born very low birth.<sup>48</sup>



### ***Singletons and Multiple Births***

Pregnancy outcomes can vary for singleton and multiple births. Multiple births include twins, triplets, and higher order births, and outcomes can vary among these groups as well.<sup>45</sup>

- In Alabama in 2006, 96.3 percent of all live births were singleton births and 3.7 percent were multiple births.



- Between 1996 and 2006, the multiple birth ratio in Alabama increased 33 percent.
- Compared with singleton births (one baby), multiple births in Alabama were about four times as likely to be preterm in 2006.

## ***Smoking and Drug use During Pregnancy***

The use of nicotine, alcohol, and drugs during pregnancy are other factors contributing to infant death and low birthweight. Smoking is associated with low birthweight, Sudden Infant Death Syndrome, and respiratory causes of infant deaths. Alcohol use during pregnancy can cause serious birth defects. Alcohol consumption during pregnancy is a leading cause of mental retardation and developmental delays. Illicit drug use during pregnancy can cause long-term health problems for the mother and child. Intravenous drug users and offspring are at particular risk for contracting Hepatitis B and HIV/AIDS. Pregnant women who use cocaine are at risk of preterm labor and their children are at an increased risk for neurological developmental problems. Methamphetamine and methadone are the emerging drugs of choice for many women in Alabama.<sup>40</sup> The fetal effects of these substances are creating serious challenges for perinatal providers.<sup>45</sup>

Prenatal exposure to methamphetamine (meth) changes the structure of a baby's brain. In a study published in the Journal of Neuroscience, UCLA researchers used magnetic resonance imaging (MRI) to examine the brains of 21 children ages five and older who were born to meth-using mothers. Compared to normal kids, the meth-exposed children had a smaller part of the brain called the caudate nucleus, which is associated with memory, learning, motivation, and motor control.<sup>45</sup>

- In 2007, 10.2 percent of Alabama women of childbearing age (18-44 years) reported binge drinking in the past month, compared to 14.6 percent overall in the United States.
- In 2007, 23.2 percent of Alabama women of childbearing age (18-44 years) reported smoking, compared to 21.2 percent of women overall in the U.S.<sup>8,28</sup>

## ***Birth Defects Overview***

Birth defects are generally referred to as abnormalities of structure, function, or metabolism (body chemistry) present at birth that result in physical or mental disabilities or death.<sup>45</sup>

- Every 4 1/2 minutes, a baby is born with a birth defect in the United States.
- In 2005, birth defects accounted for about one in six infant deaths in Alabama.

## ***Births to Teens***

Teen births produce multifaceted consequences that impact families and society. Teens are more likely to have very low or extremely low birthweight infants and birthweight is the factor most clearly related to infant death. Infant mortality rates are highest for babies of teen mothers. Additionally, the low breastfeeding rate among adolescent mothers increases the morbidity risk for these infants.<sup>45</sup>



The rate of inadequate prenatal care among births to women under age 20 (19.1 percent) was about three times the rate among women ages 30-39 (6.8 percent).

- Of all infants born during 2004-2006 (average), 13.6 percent were to mothers under the age of 20.
- In Alabama during 2004-2006 (average), mothers under age 20 (19.1percent) had the highest rates of inadequate prenatal care compared to other maternal age categories.<sup>45,50</sup>

### ***Socioeconomic Status of the Family***

Living in poverty is a factor that has been linked as a cause for infant mortality. Persons in poverty are defined as those who make less than 100 percent of the poverty threshold established by the U.S. Census Bureau. The poverty threshold for a family of three was \$15,577 in 2005, \$16,079 in 2006, and \$16,530 in 2007. During 2005-2007 (average), 18.5 percent or about one in five women of childbearing age (ages 15-44) in Alabama were living in families with incomes below the Federal Poverty Level.<sup>50</sup>

### ***Uninsured***

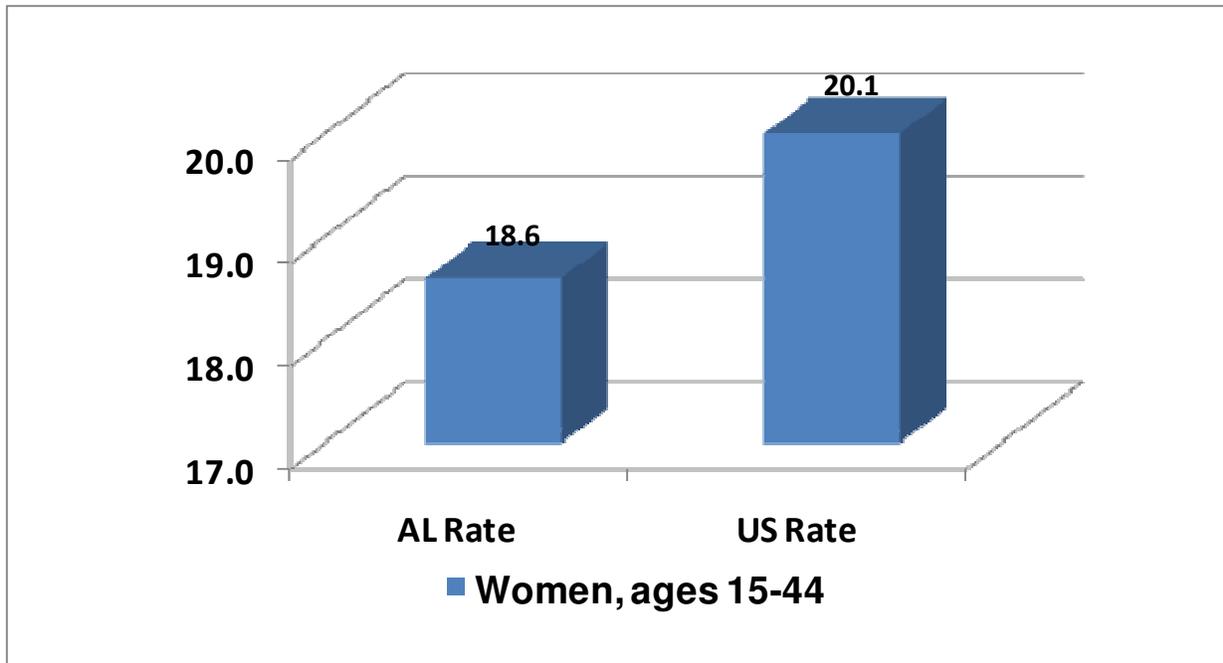
Many women do not have health insurance. Studies have consistently shown the adverse consequences of being uninsured, including lower receipt of preventive services, delays in seeking treatment for acute illnesses, higher use of emergency room services, higher rates of bankruptcy, and even higher rates of mortality.



Uninsured pregnant women are less likely than insured women to receive proper health and preventive care. Access to adequate early prenatal care may be determined by the availability of health insurance coverage for the pregnant mother.

Under current federal and state policies, Medicaid is the primary mechanism for extending health coverage for low-income, uninsured women. In 2008, 14.6 percent of all women in Alabama relied on Medicaid for health care coverage. Because nearly two-thirds (63 percent) of the women covered by Medicaid are of childbearing age (19–44 years), the program's performance is related to preconception care access and to the outcomes of pregnancy.<sup>3</sup>

In 2008, infants of mothers with no insurance coverage and who did not qualify for Medicaid had the highest infant mortality rate at 20.1 infant deaths per 1,000 live births. Medicaid babies had a rate of 10.8 infant deaths per 1,000 live births and those whose mothers had private insurance had the lowest infant mortality rate at 6.9 infant deaths per 1,000 live births. During 2008, Medicaid paid for 49.5 percent of births.<sup>45</sup>



### Uninsured Women: Alabama and U.S., 2006-2008 Average<sup>57</sup>

- During 2006 to 2008 (average), about one in five women of childbearing age (18.6 percent) was uninsured in Alabama.
- 49.6 percent of births in Alabama were covered under Medicaid in 2009.



Health Insurance Coverage of Women: Alabama and U.S., 2007-2008<sup>57</sup>

HEALTH INSURANCE COVERAGE OF NONELDERLY WOMEN 0-64, STATES (2007-2008), U.S. (2008)				
	AL RATE	AL PERCENT	U.S. RATE	U.S. PERCENT
EMPLOYER	963,600	67.90%	58,404,800	62.60%
INDIVIDUAL	58,200	4.10%	5,516,900	5.90%
MEDICAID	119,000	8.40%	9,567,900	10.20%
OTHER PUBLIC	49,900	3.50%	3,024,500	3.20%
UNINSURED	228,500	16.10%	16,853,700	18.10%
TOTAL	1,419,200	100.00%	93,367,800	100.00%

HEALTH INSURANCE COVERAGE OF WOMEN 19-64, STATES (2007-2008), U.S. (2008)				
	AL RATE	AL PERCENT	U.S. RATE	U.S. PERCENT
EMPLOYER	1,325,600	66.00%	79,301,800	60.20%
INDIVIDUAL	77,200	3.80%	7,131,900	5.40%
MEDICAID	294,100	14.60%	21,021,000	15.90%
OTHER PUBLIC	58,200	2.90%	3,638,100	2.80%
UNINSURED	253,100	12.60%	20,740,900	15.70%
TOTAL	2,008,200	100.00%	131,833,600	100.00%

**Underinsured**

Millions of childbearing age (15–44) women lack adequate health coverage, i.e., uninsured or underinsured, and others live in medically underserved areas. One-third of low-income women indicate that lack of insurance affects their access to care, 2.5 times the rate of women with higher incomes.<sup>57</sup>

Health centers are a primary source of care for millions of low-income and uninsured women. Nearly 30 percent of all patients are women of childbearing age, and Federally Qualified Health Centers (FQHCs) provided prenatal care to over 330,000 women in 2003. FQHC patients account for one out of every ten U.S. births.

Research on FQHCs shows that patients have less infant mortality and low birthweight, fewer health disparities, improved care for chronic conditions, and improved access to primary and preventive care. A study of four states clinics suggests that FQHCs may be an important source of reproductive health services to reduce unintended pregnancies and teen births.<sup>40</sup>



# M

## ENTAL HEALTH

In 2005, there were an estimated 24.6 million adults aged 18 or older who experienced Serious Psychological Distress (SPD). Research shows that ages 18-25 years have the highest prevalence of mental health concerns, yet, this age group has the lowest rate of help-seeking behaviors.<sup>51</sup>

### Incidence

In August 2008, the Center for Mental Health Services (CMHS) reported 5.4 percent of Alabama's adult population has or will experience a serious mental illness in their lifetime, accounting for some 188,504 individuals. CMHS reports that as many as 20 percent of Alabama's adult population has or will have a mental illness during their lifetime.<sup>52</sup>

According to the study, *Global Burden of Disease*, mental illness is the second leading source of disease burden in established market economies. Major depression takes an enormous toll on functional status, productivity, and quality of life, and is associated with elevated risk of heart disease and suicide.<sup>42</sup>

### Mortality

Alabama ranked 28 in the nation in the rate of suicide deaths according to the Substance Abuse and Mental Health Service Administration (SAMHSA). In 2008, 603 Alabama lives were lost to suicide. More than 19 million adults in the U.S. suffer from depression. Major depression is the leading cause of disability and is the cause of more than two-thirds of the suicides yearly.<sup>53</sup>

### Disparity

Youth suicide rates vary widely among different racial and ethnic groups. In 2001, White youth had a suicide rate of 11.5 per 100,000, compared to rates of 7.3 for African Americans, 6.1 for Hispanics, 6.4 for Asian Americans, and 18.8 for American Indians and Alaskan Natives.<sup>54</sup>

- Among American Indians/Alaska Natives ages 15-34 years, suicide is the second leading cause of death.
- Suicide rates among American Indian/Alaskan Native adolescents and young adults ages 15 to 34 (19.7 per 100,000) are 1.8 times higher than the national average for that age group (11.1 per 100,000).
- Hispanic female high school students in grades 9-12 reported a higher percentage of suicide attempts (14.0 percent) than their White, non-Hispanic (7.7 percent) or African American, non-Hispanic (9.9 percent) counterparts.
- A shortage of service exists for ages 18-25 years, with many in this age group underinsured or uninsured.



Figures

SUICIDE MORTALITY RATES BY RACE/ETHNICITY ALABAMA, 2000-2008<sup>42</sup>

	RACE	2000	2008	TOTAL PERCENTAGE CHANGE 2000–2008	STATUS	DISPARITY
Suicides	AFRICAN AMERICAN	5.6	5.4	-3.6	decreased	African Americans have a much lower suicide death rate than Whites when rates are compared between 2000 to 2008.
	WHITE	16.2	16.1	-0.6	decreased	

Mortality rates are per 100,000 population.

To calculate the rate/percentage change: Take the Old value (2000) and subtract from the New value (2008), then divide by the Old value (2000), and then multiply by 100. Formula= (2008-2000)/2000 x 100.

The disparity is based on the rate ratio between African Americans and Whites. A rate ratio is calculated by dividing the African American Rate by the White Rate in a given year. The disparity is represented as a percentage.

Lifestyle

Stigma, discrimination, poverty, and segregation from society (hospitals, institutions, group homes) toward individuals with mental illness is a major hindrance to recovery. Recovery requires services that are culturally and linguistically appropriate for individuals with mental illness and effective communication between the mental health provider and patient is essential. Recovery is an individual process in which a person with mental illness reclaims a sense of who they are in mind, body, and spirit.<sup>41</sup>

- Stigma presents a barrier to individuals seeking mental health services. The Alabama Department of Mental Health and Mental Retardation (ADMH) has partnered for the past five years with the National Alliance for the Mentally Ill of Alabama (NAMI-AL) to reduce stigma through media campaigns.<sup>55</sup>
- Build on the current efforts to reach young adult communities by developing radio and print public service announcements to address mental health awareness among Alabama’s African American, Native Hawaiian/Pacific Islander, American Indian/Alaska Native, Asian American, and Hispanic/Latino populations.
- Expansion of statewide consumer-run mental health organizations offering services to adults, particularly for ages 18-25 years, is a necessity for Alabama citizens who experience mental illness.
- Legislation to fund specialized services for individuals transitioning from child and adolescent services needs to be addressed.

## SUMMARY



As discussed throughout the Alabama Health Disparities Status Report 2010, the racial and ethnic minorities have higher rates of disease, injury, premature death, and disability. This report has provided health data that shows that racial and ethnic minority populations continue to experience poorer health outcomes resulting in higher levels of illness and death.

Eliminating health disparities will require ongoing knowledge about the factors that contribute to these disparities, such as poverty, unequal access to care, and education. It also will require enhanced methods for disease prevention and health promotion, as well as new approaches to engage and assemble affected communities by creating new health partnerships focused on eliminating health disparities.

It is the mission of the State Office of Minority Health of the Alabama Department of Public Health to continue working with all partners, so that all Alabamians can have access to quality health care which will assist in reducing or eliminating health disparities that exist, particularly in minority populations.



# TABLES



**STATISTICS—ALABAMA**  
**United States Census 2008**

<b>ALABAMA CENSUS STATE &amp; COUNTY QUICKFACTS</b>		
<b>PEOPLE QUICKFACTS</b>	<b>Alabama</b>	<b>USA</b>
Population, 2008 estimate	4,661,900	304,059,724
Population, percent change, April 1, 2000, to July 1, 2008	4.80%	8.00%
Population estimates base (April 1) 2000	4,447,355	281,424,602
Persons under 5 years old, percent, 2008	6.70%	6.90%
Persons under 18 years old, percent, 2008	24.10%	24.30%
Persons 65 years old and over, percent, 2008	13.80%	12.80%
Female persons, percent, 2008	51.60%	50.70%
<b>PEOPLE QUICKFACTS/RACE-ETHNICITY</b>	<b>Alabama</b>	<b>USA</b>
White persons, percent, 2008 (a)	71.0%	79.80%
African American persons, percent, 2008 (a)	26.40%	12.80%
American Indian and Alaska Native persons, percent, 2008 (a)	0.50%	1.00%
Asian persons, percent, 2008 (a)	1.00%	4.50%
Native Hawaiian and Other Pacific Islander, percent, 2008 (a)	<b>Z</b>	0.20%
Persons reporting two or more races, percent, 2008	1.10%	1.70%
Persons of Hispanic or Latino origin, percent, 2008 (b)	2.90%	15.40%
White persons not Hispanic, percent, 2008	68.40%	65.60%
<p><b>(a) Includes persons reporting only one race.</b>  <b>(b) Hispanics may be of any race, so also are included in applicable race categories.</b>  <b>Z: Value greater than zero but less than half unit of measure shown.</b></p>		
<p>Source U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, Census of Population and Housing, Small Area Income and Poverty Estimates, State and County Housing Unit Estimates, County Business Patterns, Non-employer Statistics, Economic Census, Survey of Business Owners, Building Permits, Consolidated Federal Funds Report / Last Revised: Friday, 04-Sep-2009 15:26:49 EDT. Web. 11 Nov, 2009.</p>		



**STATISTICS—ALABAMA & STATE SELECTED MEASURES**  
**National Healthcare Quality Report (NHQR) 2007<sup>10</sup>**

The following ranking shows how well this state is performing among all the states on 15 important measures of health care quality from the 2007 National Healthcare Quality Report. These measures were selected to represent a broad range of many common diseases.

Measure <sup>1</sup>	Definition	All-State Average <sup>2</sup>	State Rate	State Rank
<b>CANCER</b>				
Breast cancer deaths	Breast cancer deaths per 100,000 female population per year	24.4	24.1	25
Colorectal cancer deaths	Colorectal cancer deaths per 100,000 population per year	17.8	19.1	37
<b>DIABETES</b>				
Diabetes flu shots	Percent of non-institutionalized high-risk adults ages 18-64 with diabetes who had an influenza immunization in the past year	36.3	28	45
<b>END-STAGE RENAL DISEASE</b>				
Dialysis and good urea reduction - Medicare	Percent of Medicare hemodialysis patients with urea reduction ratio 65 percent or higher	92.8	92.4	34
<b>HEART DISEASE</b>				
Heart attack - beta blocker at discharge	Percent of heart attack patients with a beta-blocker prescribed at discharge, all payers	95.3	93.4	38
Heart attack - ACEI or ARB at discharge	Percent of heart attack patients with left ventricular systolic dysfunction prescribed an ACE inhibitor or an angiotensin receptor blocker at discharge, all payers	83.9	82.9	31
<b>MATERNAL AND CHILD HEALTH</b>				
Prenatal care	Percent of pregnant women receiving prenatal care in first trimester	83.8	84	22
Children fully vaccinated	Percent of children age 19-35 months who received all recommended vaccines (4:3:1:3:3)	81.8	83.3	17
<b>MENTAL HEALTH</b>				
Suicide deaths	Suicide deaths per 100,000 population	10.4	11.7	25
<b>RESPIRATORY DISEASE</b>				
Pneumonia vaccine ever - age 65 plus	Percent of adults age 65 and over who ever received a Pneumococcal vaccination	66	62	44

**1** Further details on measure specifications are available in the NHQR Measure Specifications Appendix.

**2** These all-state averages are consistently calculated across all measures and differ slightly from those in the National Healthcare Quality Report. For more information, select the Methods page.<sup>10</sup>



**STATISTICS—CANCER**

RACE	2000	2008	TOTAL PERCENTAGE CHANGE 2000–2008	STATUS	DISPARITY
<b>CANCER SCREENING MAMMOGRAM: Women who received screening tests in the last two years:</b>					
<i>Females aged 40 and over.</i>					
TOTAL POPULATION	74.9%	71.2%	-4.9%	decreased	There is no disparity between African Americans and Whites for the years 2000 to 2008.
AFRICAN AMERICAN	79.4%	75.0%	-5.5%	decreased	
WHITE	74.1%	70.5%	-4.9%	decreased	
<i>Females aged 50 and over, past 2 years.</i>					
TOTAL POPULATION	76.7%	73.2%	-4.6%	decreased	There is no disparity between African Americans and Whites for the years 2000 to 2008.
AFRICAN AMERICAN	78.0%	76.9%	-1.4%	decreased	
WHITE	76.4%	72.8%	-4.71%	decreased	
<b>CANCER: SCREENING PAP TEST: Adults aged 18 and older who receive screening tests:</b>					
<i>Females aged 18 and over past 3 years.</i>					
TOTAL POPULATION	86.6%	79.8%	-7.9%	decreased	There is no disparity between African Americans and Whites for the years 2000 to 2008.
AFRICAN AMERICAN	88.5%	82.8%	-6.4%	decreased	
WHITE	85.7%	79.2%	-7.6%	decreased	
<b>CANCER: SCREENING COLORECTAL</b>					
<i>50 years and older fecal occult blood test last two years.</i>					
TOTAL POPULATION	17.6% (1999)	20.5% (2008)	16.5%	increased	There is no disparity between African Americans and Whites for the years 1999 to 2008.
AFRICAN AMERICAN	16.7% (1999)	21.3% (2008)	27.5%	increased	
WHITE	17.7% (1999)	20.1% (2008)	13.6%	increased	
<i>Colonoscopy/Proctosigmoidoscopy, 50+.</i>					
TOTAL POPULATION	41.2% (1999)	59.3% (2008)	43.9%	increased	There is no disparity between African Americans and Whites for the years 1999 to 2008.
AFRICAN AMERICAN	39.4% (1999)	53.2% (2008)	35.0%	increased	
WHITE	41.9% (1999)	61.2% (2008)	46.1%	increased	
<b>CANCER: SCREENING: PROSTATE: Men age 40+ who have had a PSA test within the past two years.</b>					
TOTAL POPULATION	56.0% (2002)	57.7% (2008)	3.0%	increased	NA
AFRICAN AMERICAN	NA	54.9% (2008)	NA	NA	
WHITE	56.3% (2002)	59.4% (2008)	5.5%	increased	
To calculate the rate/percentage change: Take the Old value (2000) and subtract from the New value (2008), then divide by the Old value (2000), and then multiply by 100. Formula= (2008-2000)/2000 x 100. The disparity is based on the rate ratio between African Americans and Whites. A rate ratio is calculated by dividing the African American Rate by the White Rate in a given year. The disparity is represented as a percentage.					

# TABLES



RACE	2000	2008	TOTAL PERCENTAGE CHANGE 2000–2008	STATUS	DISPARITY
<b>CARDIOVASCULAR DISEASE DEATH RATES</b>					
<i>Coronary heart disease</i>					
TOTAL POPULATION	177.6	128.8	-27.5	<b>decreased</b>	There is no disparity when comparing heart disease between African Americans and Whites.
AFRICAN AMERICAN	142.1	98.3	-30.8	<b>decreased</b>	
WHITE	197.2	144.2	-26.9	<b>decreased</b>	
<i>Strokes</i>					
TOTAL POPULATION	71.4	60.4	-15.4	<b>decreased</b>	There is no disparity when comparing heart disease between African Americans and Whites.
AFRICAN AMERICAN	71.9	60.7	-15.6	<b>decreased</b>	
WHITE	74.1	62.0	-16.3	<b>decreased</b>	
<b>HEART DISEASE AND STROKE: Cardiovascular Disease: Reduce Stroke Deaths</b>					
<i>Stroke Deaths</i>					
TOTAL POPULATION	71.4	60.4	-15.4	<b>decreased</b>	There is no disparity when comparing heart disease between African Americans and Whites.
AFRICAN AMERICAN	71.9	60.7	-15.6	<b>decreased</b>	
WHITE	74.1	62.0	-16.3	<b>decreased</b>	
<b>HEART DISEASE DEATHS</b>					
<i>Heart Disease Deaths</i>					
TOTAL POPULATION	300.3	259.4	-13.6	<b>decreased</b>	There is no disparity when comparing heart disease between African Americans and Whites.
AFRICAN AMERICAN	257.1	217.0	-15.6	<b>decreased</b>	
WHITE	327.5	283.4	-13.5	<b>decreased</b>	
<b>HEART DISEASE AND STROKE: Cardiovascular Disease: Prevalence of Reported High Blood Cholesterol</b>					
<i>High Blood Cholesterol</i>					
TOTAL POPULATION	33.2 (1999)	39.6 (2009)	19.3	<b>increased</b>	There is no disparity when comparing high blood cholesterol between African Americans and Whites.
AFRICAN AMERICAN	28.2 (1999)	34.5(2009)	22.3	<b>increased</b>	
WHITE	35.0 (1999)	40.7(2009)	16.3	<b>increased</b>	
<b>HEART DISEASE AND STROKE: Cardiovascular Disease: Prevalence of Reported High Blood Pressure</b>					
<i>High Blood Pressure</i>					
TOTAL POPULATION	31.2 (1999)	37.1 (2009)	18.9	<b>increased</b>	The disparity has worsened from 19 percent higher for African Americans to 22 percent higher.
AFRICAN AMERICAN	36.4 (1999)	43.1 (2009)	18.4	<b>increased</b>	
WHITE	30.6 (1999)	35.3 (2009)	15.4	<b>increased</b>	
To calculate the rate/percentage change: Take the Old value (2000) and subtract from the New value (2008), then divide by the Old value (2000), and then multiply by 100. Formula= (2008-2000)/2000 x 100.					
The disparity is based on the rate ratio between African Americans and Whites. A rate ratio is calculated by dividing the African American Rate by the White Rate in a given year. The disparity is represented as a percentage.					



**STATISTICS—DIABETES**

RACE	2000	2008	TOTAL PERCENTAGE CHANGE 2000–2008	STATUS	DISPARITY
<b>DIABETES / KIDNEY DISEASE</b>					
TOTAL POPULATION	3.7	6.7	81.1	increased	The disparity has improved from 335% higher in 2000 to 167% higher in 2008 for African Americans when compared to Whites.
AFRICAN AMERICAN	8.7	12.8	47.1	increased	
WHITE	2.0	4.8	140	increased	
<b>DIABETES / KIDNEY DISEASE: Vaccination - Flu in Last Year.</b>					
AFRICAN AMERICAN	50.0	37.8	-24.4	decreased	There is no disparity between African Americans and Whites.
WHITE	62.7	50.0	-20.3	decreased	
<b>DIABETES / KIDNEY DISEASE: Hgb A1c in Last Year.</b>					
TOTAL POPULATION	76.5	71.7	-6.3	decreased	There is no disparity between African Americans and Whites.
AFRICAN AMERICAN	75.2	67.1	-10.8	decreased	
WHITE	77.1	76.7	-0.5	decreased	
<b>DIABETES / KIDNEY DISEASE: Dilated Eye Exam in Last Year.</b>					
TOTAL POPULATION	68.0	66.6	-2.1	decreased	The disparity has improved from 10% higher in 2000 to 3% higher in 2008 for African Americans when compared to Whites.
AFRICAN AMERICAN	75.2	68.3	-9.2	decreased	
WHITE	68.2	66.2	-2.9	decreased	
<b>DIABETES / KIDNEY DISEASE: Foot Check by Provider.</b>					
TOTAL POPULATION	62.2	64.9	4.3	same	The disparity has improved from 34% higher in 2000 to 24% higher in 2008 for African Americans when compared to Whites.
AFRICAN AMERICAN	79.1	74.0	-6.4	decreased	
WHITE	59.2	59.9	1.2	same	
<b>DIABETES / KIDNEY DISEASE: Self Foot Check - Daily.</b>					
TOTAL POPULATION	74.5	71.2	-4.4	decreased	The disparity has improved from 34% higher in 2000 to 5% higher in 2008 for African Americans when compared to Whites.
AFRICAN AMERICAN	68.8	72.7	5.7	increased	
WHITE	79.2	69.2	-12.6	decreased	
<b>DIABETES / KIDNEY DISEASE: Blood Sugar Levels - Daily Check.</b>					
TOTAL POPULATION	54.2	61.7	13.8	increased	African Americans are known to check their blood sugar levels daily more than Whites.
AFRICAN AMERICAN	49.4	62.4	26.3	increased	
WHITE	57.2	61.2	7.0	increased	
<p>To calculate the rate/percentage change: Take the Old value (2000) and subtract from the New value (2008), then divide by the Old value (2000), and then multiply by 100. Formula= (2008-2000)/2000 x 100.</p> <p>The disparity is based on the rate ratio between African Americans and Whites. A rate ratio is calculated by dividing the African American Rate by the White Rate in a given year. The disparity is represented as a percentage.</p>					



STATISTICS—HIV/AIDS

ADPH, Division of HIV/AIDS Prevention and Control			
PERCENTAGE OF POPULATION LIVING WITH HIV/AIDS*			
	No. of Cases	Total Pop	HIV/AIDS %
WHITE	3,197	3,190,994	0.10
AFRICAN AMERICAN	6,699	1,220,977	0.55
HISPANIC	216	134,810	0.16
AMERICAN INDIAN/ALASKA NATIVE	10	22,843	0.04
ASIAN AMERICAN	17	43,656	0.04
NATIVE HAWAIIAN/PACIFIC ISLANDER	4	1,409	0.28
MULTI-RACE	93	47,211	0.20
UNKNOWN	77	N/A	N/A
<b>TOTAL</b>	<b>10,313</b>	<b>4,661,900</b>	<b>0.22</b>
PERCENTAGE OF POPULATION LIVING WITH HIV*			
	No. of Cases	Total Pop	HIV/AIDS %
WHITE	1,844	3,190,994	0.06
AFRICAN AMERICAN	3,897	1,220,977	0.32
HISPANIC	111	134,810	0.08
AMERICAN INDIAN/ALASKA NATIVE	10	22,843	0.04
ASIAN AMERICAN	11	43,656	0.03
NATIVE HAWAIIAN/PACIFIC ISLANDER	2	1,409	0.14
MULTI-RACE	46	47,211	0.10
UNKNOWN	71	N/A	N/A
<b>TOTAL</b>	<b>5,992</b>	<b>4,661,900</b>	<b>0.13</b>
PERCENTAGE OF POPULATION LIVING WITH AIDS*			
	No. of Cases	Total Pop	HIV/AIDS %
WHITE	1,353	3,190,994	0.04
AFRICAN AMERICAN	2,802	1,220,977	0.23
HISPANIC	105	134,810	0.08
AMERICAN INDIAN/ALASKA NATIVE	0	22,843	0.00
ASIAN AMERICAN	6	43,656	0.01
NATIVE HAWAIIAN/PACIFIC ISLANDER	2	1,409	0.14
MULTI-RACE	47	47,211	0.10
UNKNOWN	6	N/A	N/A
<b>TOTAL</b>	<b>4,321</b>	<b>4,661,900</b>	<b>0.09</b>
*Reported Cases as of December 2008 <sup>42</sup>			



**STATISTICS—HIV/AIDS**

RACE	2000	2008	TOTAL PERCENTAGE CHANGE 2000–2008	STATUS	DISPARITY
<b>HIV INCIDENCE: Diagnosed HIV infection in adolescents and adults.</b>					
AFRICAN AMERICAN	12.3	9.9	-19.5	decreased	The disparity has improved from 624% in 2000 to 607% in 2008 in African Americans when compared to Whites.
WHITE	1.7	1.4	-17.6	decreased	
<p>To calculate the rate/percentage change: Take the Old value (2000) and subtract from the New value (2008), then divide by the Old value (2000), and then multiply by 100. Formula= <math>(2008-2000)/2000 \times 100</math>.</p> <p>The disparity is based on the rate ratio between African Americans and Whites. A rate ratio is calculated by dividing the African American Rate by the White Rate in a given year. The disparity is represented as a percentage.</p>					



**STATISTICS—INFANT MORTALITY**

RACE	2000	2008	TOTAL PERCENTAGE CHANGE 2000–2008	STATUS	DISPARITY
<b>INFANT MORTALITY</b>					
<i>All infants</i>					
TOTAL POPULATION	9.4	9.5	1.1	same	The disparity has improved from 142% higher in 2000 to 85% higher in 2008 for African Americans when compared to Whites.
AFRICAN AMERICAN	15.7	14.1	-10.2	decreased	
HISPANIC	4.7	8.9	89.4	increased	
WHITE	6.5	7.6	16.9	same	
<b>INFANT MORTALITY, ADOLESCENT PREGNANCIES</b>					
<i>All females aged 10-17</i>					
TOTAL POPULATION	21.1	16	-24.2	decreased	The disparity has worsened from 99% higher in 2000 to 108% higher for African Americans when compared to Whites.
AFRICAN AMERICAN	32.3	24.8	-23.2	decreased	
WHITE	16.2	11.9	-26.5	decreased	
<b>Low Birthweight</b>					
<i>All infants</i>					
TOTAL POPULATION	9.7	10.6	9.3	increased	The disparity has worsened from 82% higher in 2000 to 92% higher in 2008 for African Americans when compared to Whites.
AFRICAN AMERICAN	14.0	15.9	13.6	increased	
HISPANIC	6.5	6.9	6.2	same	
WHITE	7.7	8.3	7.8	same	
<b>Unintended Births</b>					
<i>Unplanned pregnancies</i>					
TOTAL POPULATION	51.9	57.2	10.2	increased	African Americans have a much lower rate of unplanned pregnancies when compared to Whites.
AFRICAN AMERICAN	28.8	34.4	19.4	increased	
WHITE	63.0	65.3	3.7	same	
<b>REPEAT BIRTH TO TEENS</b>					
<i>Repeat pregnancies</i>					
TOTAL POPULATION	10.5	8.7	-17.1	decreased	The disparity has improved from 59% higher in 2000 to 12% higher for African Americans when compared to Whites.
AFRICAN AMERICAN	12.9	9.3	-27.9	decreased	
WHITE	8.1	8.1	0.0	same	
To calculate the rate/percentage change: Take the Old value (2000) and subtract from the New value (2008), then divide by the Old value (2000), and then multiply by 100. Formula= (2008-2000)/2000 x 100.					
The disparity is based on the rate ratio between African Americans and Whites. A rate ratio is calculated by dividing the African American Rate by the White Rate in a given year. The disparity is represented as a percentage.					



**STATISTICS—INFANT MORTALITY**

RACE	2000	2008	TOTAL PERCENTAGE CHANGE 2000–2008	STATUS	DISPARITY
<b>PRENATAL CARE: All live-born infants whose mothers received adequate prenatal care.</b>					
TOTAL POPULATION	76.7	74.2	-3.3	decreased	There is no disparity when comparing adequate prenatal care between African Americans and Whites.
AFRICAN AMERICAN	68.1	70.5	3.5	increased	
HISPANIC	50.1	44.5	-11.2	decreased	
WHITE	80.9	76.5	-5.4	decreased	
<b>SMOKED DURING PREGNANCY</b>					
TOTAL POPULATION	12.5	12.0	-4.0	decreased	More African American women are smoking during pregnancy in 2008 when compared to data in 2000.
AFRICAN AMERICAN	5.5	6.5	18.2	increased	
HISPANIC	1.8	1.0	-44.4	decreased	
WHITE	16.2	14.8	-8.6	decreased	
<b>CONSUMED ALCOHOL DURING PREGNANCY</b>					
AFRICAN AMERICAN	0.7	0.3	-57.1	decreased	The disparity has improved from 40% in 2000 to 10% in 2008 for African Americans when compared to Whites.
HISPANIC	0.3	0.2	-33.3	decreased	
WHITE	0.5	0.5	0	same	
<b>WOMEN WITHOUT INSURANCE DURING PREGNANCY</b>					
TOTAL POPULATION	2.4	4.2	75.0	increased	The disparity worsened from <1% in 2000 to 12% in 2008 for African Americans when compared to Whites.
AFRICAN AMERICAN	1.5	4.4	193.3	increased	
HISPANIC	31.6	19.8	-37.3	decreased	
WHITE	2.8	3.9	39.3	increased	
<p>To calculate the rate/percentage change: Take the Old value (2000) and subtract from the New value (2008), then divide by the Old value (2000), and then multiply by 100. Formula= <math>(2008-2000)/2000 \times 100</math>.</p> <p>The disparity is based on the rate ratio between African Americans and Whites. A rate ratio is calculated by dividing the African American Rate by the White Rate in a given year. The disparity is represented as a percentage.</p>					



STATISTICS—MENTAL HEALTH

RACE	2000	2008	TOTAL PERCENTAGE CHANGE 2000–2008	STATUS	DISPARITY
<b>SUICIDE DEATHS</b>					
AFRICAN AMERICAN	5.6	5.4	-3.6	decreased	African Americans have a much lower suicide death rate when compared to Whites.
WHITE	16.2	16.1	-0.6	decreased	
<b>MENTAL HEALTH AND MENTAL DISORDERS, ADULTS 18 AND OLDER: Depression: <i>How many days during the past 30 days was your mental health good (mental health includes stress, depression, and problems with emotions)?</i></b>					
TOTAL POPULATION	30.2	35.9	18.9	increased	African Americans have less episodes of stress and depression when compared to Whites.
AFRICAN AMERICAN	23.7	30.2	27.4	increased	
WHITE	29.7	38.3	28.9	increased	
<p>To calculate the rate/percentage change: Take the Old value (2000) and subtract from the New value (2008), then divide by the Old value (2000), and then multiply by 100. Formula= <math>(2008-2000)/2000 \times 100</math>.</p> <p>The disparity is based on the rate ratio between African Americans and Whites. A rate ratio is calculated by dividing the African American Rate by the White Rate in a given year. The disparity is represented as a percentage.</p>					



**STATISTICS—OVERWEIGHT AND NUTRITION**

RACE	2000	2008	TOTAL PERCENTAGE CHANGE 2000–2008	STATUS	DISPARITY
<b>NUTRITION: Weight Status, Adults 18 and older: Prevalence of being overweight (defined as a body mass index at or above 27.8 for men and 27.3 for women) among adults aged 18 and older.</b>					
TOTAL POPULATION	36.8 (2000)	35.7 (2008)	-3.0	decreased	There was no disparity between African Americans and Whites when looking at prevalence of being overweight.
AFRICAN AMERICAN	36.1 (2000)	36.9 (2008)	2.2	increased	
WHITE	36.6 (2000)	35.1 (2008)	-4.1	decreased	
<b>NUTRITION: Weight Status, Percentage of students grades 9-12, who were overweight (i.e., &gt;= 85<sup>th</sup> percentile but &lt; 95<sup>th</sup> percentile for body mass index, by age and sex, based on reference data).</b>					
TOTAL POPULATION	15.0 (1999)	17.5 (2009)	16.7	increased	The disparity has worsened from 47% higher in 1999 to 53% higher in 2009 for African Americans when compared to Whites.
AFRICAN AMERICAN	19.5 (1999)	22.4 (2009)	14.9	increased	
WHITE	13.3 (1999)	14.6 (2009)	9.8	increased	
<b>NUTRITION: Weight Status, Percentage of students grades 9-12, who were obese (i.e., &gt;= 95<sup>th</sup> percentile for body mass index, by age and sex, based on reference data).</b>					
TOTAL POPULATION	12.4	13.4	8.1	increased	The disparity has improved from 47% higher in 2000 to 33% higher in 2009 for African Americans when compared to Whites.
AFRICAN AMERICAN	15.9	15.7	-1.3	decreased	
WHITE	10.8 (1999)	11.8 (2009)	9.3	increased	
<b>NUTRITION: Dietary Guidelines: Adults aged 18 and older who meet the dietary recommendations of a minimum average daily goal of at least five servings of vegetables and fruits.</b>					
TOTAL POPULATION	22.7	20.3 (2009)	-10.6	decreased	African Americans nor Whites eat at least five servings of vegetables and fruits.
AFRICAN AMERICAN	21.3	19.5 (2009)	-8.5	decreased	
WHITE	22.2	20.5 (2009)	-7.7	decreased	
<b>NUTRITION: Dietary Guidelines, Students, grades 9-12: Percentage of students who ate fruits and vegetables (100% fruit juices, fruit, green salad, potatoes [excluding French fries, fried potatoes, or potato chips], carrots, or other vegetables) five or more times per day during the 7 days before the survey.</b>					
TOTAL POPULATION	14.1 (1999)	16.3 (2009)	15.6	increased	The disparity has worsened from 26% higher in 1999 to 135% higher for African Americans when compared to Whites.
AFRICAN AMERICAN	16.4 (1999)	24.7 (2009)	50.6	increased	
WHITE	13.0 (1999)	10.5 (2009)	-19.2	decreased	
<p>To calculate the rate/percentage change: Take the Old value (2000) and subtract from the New value (2008), then divide by the Old value (2000), and then multiply by 100. Formula= (2008-2000)/2000 x 100.</p> <p>The disparity is based on the rate ratio between African Americans and Whites. A rate ratio is calculated by dividing the African American Rate by the White Rate in a given year. The disparity is represented as a percentage.</p>					



**STATISTICS—PHYSICAL ACTIVITY**

RACE	2000	2008	TOTAL PERCENTAGE CHANGE 2000–2008	STATUS	DISPARITY
<b>PHYSICAL ACTIVITY AND FITNESS: Adult Physical Activity: Adults, 18 and older, with 30+ minutes of any MODERATE physical activity five or more days per week.</b>					
TOTAL POPULATION	42.5 (2001)	41.0 (2009)	-3.5	decreased	There is no disparity between African Americans and Whites when comparing physical activity in adults between 2001 to 2009.
AFRICAN AMERICAN	33.9 (2001)	34.7 (2009)	2.4	increased	
WHITE	45.4 (2001)	42.2 (2009)	-7.1	decreased	
<b>PHYSICAL ACTIVITY AND FITNESS: Adolescent Physical Activity-Students, grades 9-12: Percentage of students who were physically active doing any kind of physical activity that increased their heart rate and made them breathe hard some time for a total of at least 60 minutes per day on five or more of the seven days before the survey.</b>					
TOTAL POPULATION	31.8 (2005)	37.3 (2009)	17.3	increased	There is no disparity between African Americans and Whites when comparing physical activity in students grades 9-12.
AFRICAN AMERICAN	25.3 (2005)	30.7 (2009)	21.3	increased	
WHITE	35.7 (2005)	42.2 (2009)	18.2	increased	
<p>To calculate the rate/percentage change: Take the Old value (2000) and subtract from the New value (2008), then divide by the Old value (2000), and then multiply by 100. Formula= <math>(2008-2000)/2000 \times 100</math>.</p> <p>The disparity is based on the rate ratio between African Americans and Whites. A rate ratio is calculated by dividing the African American Rate by the White Rate in a given year. The disparity is represented as a percentage.</p>					



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## AGENCY ACRONYM OR DESIGNATION

ACF	Administration for Children and Families
ADMH	Alabama Department of Mental Health and Mental Retardation
ADPH	Alabama Department of Public Health
AHRQ	Agency for Healthcare Research and Quality
AIAC	Alabama Indian Affairs Commission
AoA	Administration on Aging
BRFSS	Behavioral Risk Factor Surveillance System
CDC	Centers for Disease Control and Prevention
CHS	Center for Health Statistics, Statistical Analysis Division, Alabama Department of Public Health
CMHS	Center for Mental Health Services
CMS	Centers for Medicare & Medicaid Services, Alabama
FDA	Food and Drug Administration
HDAC	Health Disparities Advisory Council, ADPH
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
KFF	Kaiser Family Foundation
NHQR	National Healthcare Quality Report
NIH	National Institutes of Health
NPA	National Partnership for Action
OIG	Office of Inspector General
OMH	Office of Minority Health (SOMH - State Office of Minority Health)
PSC	Program Support Center
PHS	Public Health Service
PRAMS	Pregnancy Risk Assessment Monitoring System
SAMHSA	Substance Abuse and Mental Health Services Administration
YRBSS	Youth Risk Behavioral Surveillance System



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*Alabama Health Disparities Status Report 2010* is the result of work performed by a group of dedicated community and state level people. The individuals and their respected agencies are listed below. We wish to acknowledge their commitment to working toward parity in health care and in health outcomes in Alabama.

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Alabama AIDS  
Alabama Alliance for Latino Health  
Alabama Cooperative Extension System  
Alabama Department of Environmental Management  
Alabama Department of Mental Health and Mental Retardation  
Alabama Department of Public Health  
Alabama Department of Public Health, Health Disparities Advisory Council  
Alabama Department of Rehabilitation Services  
Alabama Department of Senior Services  
Alabama Indian Affairs Commission  
Alabama Medicaid Agency  
Alabama Medical Education Consortium  
Alabama Minority Health Advisory Council  
Alabama Minority Health Task Force  
Alabama Primary Health Association  
Alabama Quality Assurance Foundation  
Alabama Rural Health Association  
Alabama State University  
American Association of Retired Persons  
American Heart and Stroke Association  
Boat People SOS Bayou LaBatre  
Congregations for Public Health  
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Mid-Alabama Coalition for the Homeless  
Montgomery AIDS Outreach  
Tuskegee University National Center for Bioethics and Research  
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Status Report 2010



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